# HEALTH
# SING

ber, 1933 Number 9


## DISEASES

and FLORENCE A. AMBLER, R.N.

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# PUBLIC HEALTH NURSING

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## N.R.A. AND PUBLIC HEALTH NURSING

THE entire country has been stirred this past month by the significance of the National Recovery Administration program, and health and social work agencies are inquiring as to their responsibilities and opportunities under the "President's Reëmployment Agreement," or so-called "blanket code."

Representatives of national agencies who have conferred with the Administration in Washington are awaiting a public statement as to whether social agencies legally come within the code.

Meantime, those public health nursing agencies signing the code voluntarily will be affected chiefly in regard to the hours and pay of their non-professional staffs. It is understood that nurses and other professional workers are not influenced. Agencies wishing to sign the code are advised to consult with their own boards and with the Community Chests (in Chest cities) to see how adjustments in clerical and non-professional personnel can be met.

The N.O.P.H.N. has signed the code for its clerical staff. The organization has been on record, not in the form of a code, to be sure, but in its published material, in upholding reasonable hours of work for public health nurses and salaries commensurate with their professional preparation and services.

Through its various studies the N.O.P.H.N. has found that a working day of seven and one-half hours—a forty-one hour week—is the usual practice in public health nursing agencies, although many agencies have an eight hour day and a forty-four hour week. In view of the exigencies of the nurse's program she often works overtime for the sake of her patient. The N.O.P.H.N. has suggested that this time be made up to the nurse in slack periods.

While varying costs of living throughout the country make it impossible to set a hard and fast scale of salaries, the annual salary studies made by the N.O.P.H.N.* give the general range for different types of positions. The N.O.P.H.N. Committee on Adjustments in Public Health Nursing organized during the present economic situation, has stood firmly for a salary scale that bears a direct relation to the preparation, qualifications, experience and degree of responsibility of the nursing staff.

As budgets are prepared for this Fall, public health nursing agencies will want to take into consideration that the National Recovery Administration program

*See May, 1933, PUBLIC HEALTH NURSING.

is attempting to bring about a reversal of the recent trend in salary and wage cutting. Certainly public opinion is now behind efforts to provide adequate salaries and reasonable hours, and public health nursing will welcome this new opportunity to do its part toward national recovery.

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## CAN WE AFFORD TO ATTEND MEETINGS?

Of course we can.

To stop short with this cool assertion nowadays is to display an intolerable and unwise high-handedness! Compelling *reasons* must be given to those who hold the purse strings if provision is to be made in the budget for staff attendance at professional meetings.

It is not the purpose of these remarks to review all the reasons for attendance at national meetings. This has been done many times in the past. There is one, however, to which greater consideration might be given, with profit to the nurse attending the meeting and to the organization financing the trip—namely, the potentially salutary effect on the community service itself. In the last analysis, this is the only justification for expenditures of any kind—no matter what the source of financial support.

With this object in mind as a criterion of evaluation, I am taking the liberty of reviewing the meeting of the National Tuberculosis Association held in Toronto in June, 1933—one of the best national meetings I have ever attended—to discover just what it yielded in fairly abstract terms which might redound to the benefit of the community represented by the nurse, and to the nurse's own professional development. If these observations happen to prove convincing arguments as to why we must afford to attend meetings—so much the better!

1. *The attendance exceeded all expectations.*

What, if any, significance can this fact have for the nurse who comes from a large city service or from a one-nurse county program? To me (and I must confess these are personal reactions) it was a symptom of the "new deal" in which the trend is obviously away from an individualistic and isolated performance toward greater group action. No longer can we depend upon the alibi: "Our community or situation is different". Outwardly, yes; but fundamentally it is part of the whole social scheme and therefore depends, to a degree, on understanding the whole for the greater effectiveness of its own little part. The nurse in the most sparsely settled rural area must know what is taking place in the nation as a whole in order to guide intelligently, and to a timely end, the thinking and action of her board in integrating the service in the state and national social plan. The Federal Relief Administration is but one example of the effect of national planning on local programs. And tuberculosis is a national problem.

2. *There was nothing startlingly new in the tuberculosis field.*

This was the most comforting feature (to me) of the whole meeting. No discoveries in the pathological or clinical fields that would mean a radical change of nursing emphasis or content! What a relief! And yet, I am aware of a sense of disappointment on the part of many, whose first question in relation to any field is—"What's new?"

Until some discovery is made in the treatment of tuberculosis that will markedly affect the nursing program, should we not be grateful for this opportunity of rounding out our knowledge of known facts about the disease, and perfecting our skills in sharing with the community the information which we already possess for its prevention and cure? What public health nursing needs at the moment is not so much "something new" in the way of laboratory discovery or clinical procedure to enrich its contribution to community health, as improved technique in imparting the "old".

3. *Surgery occupies a prominent place in the treatment of pulmonary tuberculosis.*

Are we sufficiently familiar with the

principles and procedures of thoracoplasty, artificial pneumothorax, phrenico-exeresis, oleothorax, and other surgical measures, so that we can explain their purpose and method in simple language to the patient for whom they are recommended? Or do we need more observation at a clinic or sanatorium in order to acquire a greater familiarity with the technique of the operation and after care?

4. *Cancer, fungus infections, and bronchiectasis occupied a larger place on the program than ever before.*

To the tuberculosis case-finding enthusiast this indicates the possibilities of enlarging fields of interest and activity by a corresponding broadening of the concept of "case-finding" beyond that of tuberculosis. It should also restrain an all-too-ready willingness to "suspect" tuberculosis, whenever such symptoms as cough, fatigue, and loss of weight are encountered. It is apparent that many other conditions beside tuberculosis can affect the lungs. This broadening of emphasis in the clinical field may well be the scientific basis upon which to build a larger case-finding program that is not concerned so much with finding a particular disease, as discovering and bringing under medical care *any* abnormality that is likely to lessen chances for health enjoyment.

5. *Silicosis is a widespread industrial hazard.*

"The sum and substance of all the available evidence is that silicosis is a widespread industrial hazard, is probably on the increase, and affects to an appreciable extent the tuberculosis death rate among industrial workers exposed."

As public health nurses in industry, are we familiar with the industrial processes in which silica dust is present, do we understand the principle underlying the safety measures approved for its control, and are we increasingly successful in securing the coöperation of the worker in their use? As agents of the department of health, do all public health nurses strengthen the program of epidemiological control by obtaining usable data on employment in family case histories? As public health nurses carrying on a generalized program of home visiting, are we working with the bread winners as much as we can—especially in communities where industry itself offers no nursing service?

6. *The paper X-ray is an increasingly useful device for screening and case finding among school children.*

Are we prepared, when seeking the consent of the parents in having this X-ray done, to explain its purpose and to tell them (in lay terms) enough about the possible findings to allay their fears? In other words, is the nurse keeping posted on current knowledge as to what takes place from the time of infection to the destructive stages of the disease—and how? Is it not a good thing for us as county nurses to know that paper is more economical than film for X-ray and therefore more nearly within reach of limited school health budgets?

7. *There is much to be learned about childhood tuberculosis.*

Clinicians are by no means agreed as to the meaning of tuberculous infection. Should a positive tuberculin reaction in a child be regarded as an asset or a liability? One group feels, as has long been taught, that infection carries with it a certain amount of acquired immunity. The other group holds that dependence on immunity so acquired is too uncertain and they point out that since the destructive form of tuberculosis results only from a reinfection of previously infected tissues, infection should be regarded as a hazard rather than a protection. All are agreed, however, that infection should be "postponed" as long as possible and that every possible effort should be made to avoid massive infection. What the nurse should tell the family in any given case must, then, agree with the interpretation which the attending physician places upon this diagnostic procedure.

8. ***Emphasis was again laid on the need for closer coördination, and in some instances amalgamation. of health agencies.***

Public health nursing is not an independent service but depends for its greatest effectiveness on productive community relationships. Occasionally, it is a healthy indulgence to take stock of our own efforts at coöperation. To ask ourselves if we have withheld anything that will make another agency more effective in serving the community, is a far healthier method of analysis than to list all the so-called non-coöperative attitudes of other agencies!

9. *The task of the health educator is "to interpret advances in science, insofar as these relate to health, into usable form for lay consumption. The principal necessity for them to observe is accuracy."*

There is sufficient evidence to show that "inaccuracies have crept into health education material through over-zealous employment of slogans and health rules, failing especially to recognize that individuals remain different, and that health advice cannot successfully be standardized. Weaknesses in health education material are: failure to admit disadvantages, to recommend procedures even when these are heavily outweighed by the advantages, unskillful use of statistics and excessive eagerness to use new and untried matter."

A survey of our own performance in the field of health education, with these weaknesses in mind as yardsticks, will inevitably result in curbing enthusiasm and delaying adoption of everything "new" in posters, slogans, and other attention-arresting printed material. It will do more than this. It will make us more conservative in our verbal claims for such invaluable measures as toxoid or toxin-antitoxin, when we realize that they do not "*always* protect against diphtheria" but in "most instances" do.

10. *This was the second annual meeting of the National Tuberculosis Association at which emphasis was placed on training, staff education, and placement.*

What a familiar ring all these topics have to the public health nurse! And yet, can we be casual about their significance to our field, even though we may have had a postgraduate course and are now employed? A static attitude toward anything is deadly these days, but more particularly fatal in relation to flexibility in the matter of adjustments within the public health field itself. Acquiring new skills and increased knowledge of our own and related fields is indispensable in the prevention of a fixed viewpoint—a sure sign of death in a changing social order.

Many other "observations" were made at this meeting, but the above may be sufficient to indicate specific ways in which attendance at a meeting can be reflected in the service of the organization to the community. To the nurse herself it can be a veritable "refresher" course. Attendance was never more important than in these days of rapid social evolution.

VIOLET H. HODGSON

# Trends in the Field of School Nursing and Their Educational Significance *

By ELMIRA BEARS WICKENDEN, R. N.
In collaboration with
MARY ELLA CHAYER, R.N.

THERE is no public health nurse today who carries on her work in more complex surroundings than the nurse who is interested primarily in the health supervision of the school age child. This seems to be true of both urban and rural nurses, though for different reasons. The rural public health nurse finds it a great advantage to use the school as the medium through which she reaches her families. Her problems are largely those of too extensive area and too thinly spread service. The city nurse, while she finds the school the same advantageous medium through which to work, is confronted with the problem of defining her program clearly enough to avoid duplication of the service offered by the community public health nurse who is entering the same home to do family teaching, including both children and adults. She needs to think very clearly also in regard to her duties in the school system as they relate to the work of teacher, physician, visiting teacher, nutritionist, and attendance officer.

When the public health nurse first entered the school health field, there was not the elaborate set-up for health work that there is today. She could work in almost any direction without disturbing the program of anyone else, and unfortunately, she is sometimes still in confusion as to her place in the schools because of the past successes and failures that have been made while trying to do other people's jobs. Today certain trends are more clearly defined, the criteria for evaluating the service are more carefully thought out, and a number of influences have been successfully at work to broaden our understanding of the nursing program with the school-age child.

## RECENT INFLUENCES

It is interesting to scan the history of school health work over the last few years and to enumerate these influences which have given impetus to a program that is more characteristically public health nursing than formerly. These are:

The continuous work of educators in clarifying their ideas regarding the place of health education in the school system and the teachers' part in the program

The work of the committees of the White House Conference on Child Health and Protection relating to the whole field of child health

The outline of "Objectives and Functions of Public Health Nurses in School Nursing Services" by a subcommittee of the National Organization for Public Health Nursing Education Committee

The fulfillment of a long standing need in the publishing of Miss Chayer's "School Nursing, A Contribution to Health Education"

The research being carried on by the American Child Health Association, results from which are being published currently

The increasing tendency to include the specialized fields of public health nursing in a generalized program, especially in rural and county work, so that the nurse may work with the family as a unit

The economic situation bringing reduction in budgets, program, personnel, and an immediate need to scrutinize the health program in order to make necessary adjustments.

While all of these developments have served to clarify the nurse's conception of her own duties, much effort still needs to be expended not only among nurses but among all other participants in the school health program. The confusion regarding the nurse's program is not all in the minds of the nurses. Because of

*Presented at the conference on the Improvement of Education during the Depression held at Teachers College, Columbia University, New York, May 13, 1933.

gradual changes in methods, attitudes, and personnel, educators and nurses begin to see in theory the place of the public health nurse in relation to the health of the school child much more clearly than ever before. Not so much progress has been made in actual practice in the field.

### CONTRIBUTIONS OF THE SCHOOL NURSE

We say that the qualified public health nurse is prepared to contribute to a coöperative program for health protection, health promotion, and health education. She can do this effectively only if she recognizes which parts of such a program are unquestionably her contribution. It is the serious and challenging nature of the present economic situation that forces us out of the ruts and puts new vitality into our work. All public health nurses have been taking account of stock. They must present a reorganized program which will be more effective as well as more economical, and surely the thinking and experimenting of the past few years have prepared us to take this next step more constructively.

Under what type of administration this program is placed and the extent to which the nurse assumes these responsibilities are matters which are always decided by the individual needs and resources of each community. We know that many of our public health nurses feel that they have the best opportunity to give a well-rounded program when they can carry on their share of health service for the schools in their family program, which enables them to include the child as part of the family unit, relating this phase of the child health work to their prenatal, infant, and preschool supervision. It is under this type of administration that the rural nurse usually works. However, regardless of the administrative supervision, the same essentials in program can be accepted as the basis for every school nurse's service.

### SIGNIFICANT CHANGES AFFECTING SERVICE

What are the significant changes which seem to be the result of these influences, and how do they affect the integral parts of a program in which the nurse participates? Among the most important are:

A wiser division of the program, which unfortunately has too often been carried by the nurse alone, among teacher, nurse, family, and school or private physician

The substitution for the old superficial method of a physical examination one that is of such improved quality, so much more thoughtfully spaced throughout the child's school life, so much more regarded as an opportunity of great educational value, that the nurse may plan follow-up work which is of the same quality and comprehensiveness

A more conscious effort to bring the work of the private physician and the school into closer and more sympathetic relationship

A carefully planned program of coöperation or coördination of community health interests that aims to provide the best possible environment for the family.

### SHARING THE PROGRAM

To discuss the first point, there is now a clear-cut plan which we may use as a guide in the development of the sound program for which the nurse is striving. We are all in accord with the theory that all health teaching should be integrated throughout and that the teacher is the logical person to carry this part of the work. While we are forced to recognize that among both teachers and nurses lack of interest or of understanding of the real value of the health program is not uncommon, we do know that improvement in teacher- and nurse-training is overcoming this deficiency.

An awareness of the teacher's aim to relate health teaching to the child's every day experience and to arouse the desire for wholesome health attitudes, and her conduct will serve the nurse well in fulfilling her own responsibilities. In assisting the teacher she has a fine opportunity to provide source material, which she will have available if her own resources are adequate. She can give invaluable help in making the daily inspection the aid it should be in the control of contagion, in enlisting the interest of the children in their own health, and in assisting the teacher to correlate health with every activity of the school life.

Conferences between teacher and nurse should be well planned and fre-

quent: to correlate the work of both; to gain a mutual understanding of aims and programs; and to give an opportunity for nurse and teacher to contribute to each other's knowledge of the individual child in relation to his work and his family. We need to be aware of the necessity for both nurse and teacher to use various materials and conduct certain routine practices in a way that will be scientifically sound so as to bring results commensurate with the time spent on them. Among the best known of these routines are weighing and measuring, first aid or emergency work, and the testing of vision and hearing. As fast as it is practicable the nurse should turn these procedures over to the teacher, and where skill is not of primary importance, the teacher can make of them opportunities for the participation of the children in the health service.

A change of heart, as well as habit, on the part of the nurse is necessary concerning first aid work. Only by teaching the children and parents how to care for these emergencies can we shift this responsibility where it belongs. The nurse in most cases will need to instruct children, parents, and teachers, but a plan for systematic care of minor accidents and illnesses should be worked out with the principal and should include the nurse only as an advisor or as the same emergency worker that all members of the school personnel must be in this respect.* Both from the viewpoint of sound practice and good economy of time the nurse should so arrange her part of this service. The elimination of long, monotonous office hours for such routine procedure will free the nurse for her real work and at the same time result in producing independence on the part of the families.

The same practice of leaving to the teacher that which is her responsibility is applicable to the work shared with all the various groups in the school personnel. The organization of a faculty group for the purpose of planning the health program and for the exchange of ideas is a necessity to the nurse if duplication of effort is to be eliminated and mutual understanding of services is to be achieved. Among the joint projects planned will be the outline and division of responsibility for classes which may include nursing care of the sick, home hygiene, child care, and first aid; an adequate program for the control of contagion; division of responsibilities with the visiting teacher; and pooling of information regarding the family environment, diet, and attitudes, where problem cases are discussed. All of this reassignment of professional services among a group of interested and well informed participants in the health program will not only bring order into the entire service to the benefit of everyone, but will permit a schedule of responsibilities for the nurse that are suited to her professional training. How it affects her program in relation to the family and physician can be brought out under our second point.

### THE NEW PLAN FOR PHYSICAL EXAMINATIONS

The substitution of a physical examination of real worth for the old hurried, superficial one has definite educational implications. The improved quality gives us results that are dependable for use as the basis of our work with each child. The nurse may have been handicapped in the past by the long array of defects presented to her for follow-up work, without discrimination as to their relative importance. The improved examination gives her the opportunity to gain a more complete picture of the child's physical condition. Her assistance to the physician brings her the opportunity to go over the results with him and to make a discriminating selection of the conditions that need her best efforts to correct or improve. What she chooses as of primary importance depends upon the physician's judgment, whether it be physical defects, behavior problems, or faulty habits.

Some interesting experiments are being tried for providing a plan of follow-up work that will give the nurse all

*See article on this subject on page 489 of this magazine.

possible chance to make what seems her best contribution to the health service of the community in the most economical way.* While the value of home visiting has never had proper emphasis, yet we recognize that poor selection of cases, travel time, multiplication of visits, can all be replaced by careful choice, better spacing, and as much saving of travel time as possible. Initial home visits made to gain first-hand knowledge of the family environment and subsequent contacts through school conferences should provide one way of decreasing quantity and improving quality of service at one stroke. The Bellevue-Yorkville Demonstration in New York City is reaching most of the parents whom it needs to contact through conferences at the school. Evening hours are arranged for working parents. Encouraging results are that the parents who respond are those most likely to be interested in their children's welfare and therefore those with whom it is most worthwhile working; the elimination of the unproductive visits and much travel time. Home visits are made to a limited extent for reported illness, minor contagion, or behavior problems, and for the generalized service which these nurses carry on in their program.

Every conference, whether made in the home or the school, should be more carefully planned as to content, and several short, hastily prepared calls could well be replaced by fewer, well-prepared visits.

Much of the work done with the adolescent child in secondary schools can be the result of the good health examination. Individual and conference work should both be stressed with this age group, because of the prevalence of tuberculosis, the problems of adolescence, the great amount of fatigue, and the poor health habits that stand out as great needs in the high schools.

It is this work with the families and children for which the nurse is best prepared by training and equipment.

### CLOSER WORK WITH THE PRIVATE PHYSICIAN

Mutual interest in the health needs of the family on the part of private physician and nurse is not new, but is more emphasized today. Old and tried resources used in obtaining correction of defects are going to be supplemented and in some cases supplanted by the more comprehensive family service which organized medical groups are offering in their effort to stimulate a "back to the family physician" movement. This development holds promise of greatly improved family health supervision and should be aided in every way by the nurse whose first efforts have always been directed toward retaining the supervision and services of the family doctor. Detroit, Cleveland, and Buffalo have all launched coöperative plans for physicians, hospitals, health workers, and social workers to put into effect.

### CLOSER COMMUNITY RELATIONSHIPS

Finally, the effort to effect closer community relationships is leading to several types of formal and informal administrative arrangements, ranging all the way from amalgamated services, joint administrations, joint advisory committees to the county unit with its thoroughly generalized nursing service. Many public health nurses in a specialized school program feel greatly handicapped in their home work because they are dealing with only one age group in the family. A nurse who has the advantage of planning with the family the health supervision of the entire unit obtains better coöperation, a more receptive attitude, and more thorough understanding of the home background, and lastly an infinitely more satisfactory situation in which to do her teaching. She has a richer contribution to make to the school if her influence has been at work to obtain proper prenatal care, infant training and feeding, prevention or early correction of defects, correct habit formation, proper diet, etc., before the child has reached school age. Deprived of this broader opportunity, the school nurse is faced with a program in which the curative and alleviative work always overbalances the preventive. Any building up of coördinated health services in a community is a decided help to the nurse.

*See Miss Randall's article, page 478 of this magazine.

### AGAIN A QUESTION OF ADEQUATE PREPARATION

We are insisting on better quality of work in plan and content. This implies the need of proper preparation and continuous education. Far too few of the 6,500 to 7,000 nurses engaged in public health nursing for the school-age group have been carefully selected for their work. They should be as well prepared for their rôle as the teachers are for theirs. The usual content of the post-graduate course offered to a nurse to prepare her for work in the field of public health nursing should be supplemented by more instruction in teaching methods, if her program is to include formal teaching of nursing material, such as is necessary in classes in home hygiene and child care.

Too little emphasis has been placed on staff education in this group of nurses. Very little effort has been made locally to enable large staffs to consider the vast amount of instructional material always at hand, or to plan periodic joint conferences in territories where one-nurse services are prevalent. Nurses in school services, by and large, have been little challenged by the obvious need for continuous education and good supervision. As in all other fields, such supervision provides educational leadership in group thinking and can only come from within the professional group.

### AND SELECTION

Better quality of service implies as well the need for better selection of nurses on the part of administrators. With well equipped nurses available, it is poor policy to choose a nurse for this important work whose only qualifications are her diploma from a school of nursing and local residence. It is equally essential that administrators recognize the need for trained supervisors to carry on a well coördinated program of work and education.

With adequate preparation and adequate supervision the nurse enriches her contribution to families, schools, and communities, and she is better equipped to accomplish her primary aim which is to help secure maximum health for every school child through his own intelligent coöperation and that of all others who control his environment.

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## THE INTERNATIONAL COUNCIL OF NURSES*

In spite of the restrictions of the world-wide economic situation, 2500 nurses from 42 countries attended the Congress of the International Council of Nurses in Paris-Brussels the week of July 9-15. Approximately 200 of these were American nurses.

Early reports are full of enthusiasm for the gracious hospitality of the French and Belgian nurses, for the excellence of the arrangements, and for the note of inspiration that closed the conference. The watchword for the next four years—"Concours" (coöperation)—given by the retiring President, Mlle. Chaptal, seems particularly timely and significant.

Seven new countries were admitted to membership: Austria, Czecho-Slovakia, Estonia, Iceland, Japan, Korea, and Hungary.

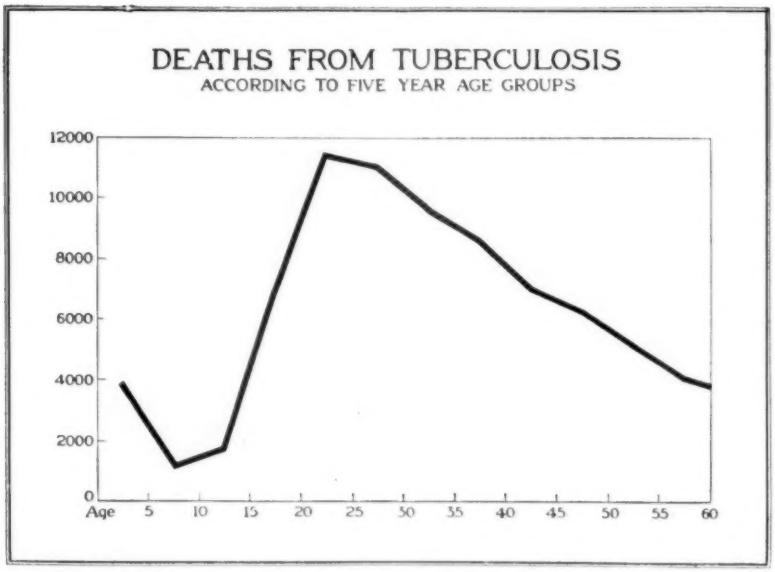
Miss Lloyd Still, Matron of St. Thomas' Hospital and Superintendent of the Nightingale Training School in London, was elected president; Miss Clara D. Noyes was reëlected first vice-president; Miss B. G. Alexander, president of the South African Trained Nurses' Association, was elected second vice-president. Miss Christiane Reimann continues as secretary and Miss E. M. Musson as treasurer.

The next Congress will be held in London in 1937.

*More detailed reports will appear in future numbers.

# Tuberculosis in School Children*

By H. E. KLEINSCHMIDT, M. D.




TUBERCULOSIS no longer stands at the head of the mortality list, but it still destroys more lives between the ages of 15 and 25 than any other disease. Thanks to the efficiency of modern treatment, many who develop the disease are, in these days, spared. But even at best, tuberculosis exacts of its survivors a bitter price in terms of productive years lost, thwarted ambitions and incomplete achievement.

A casual glance at the graph representing the distribution of deaths according to age groups tempts one to conclude that tuberculosis is an adult disease. That, however, would be a superficial judgment, for the graph represents merely the harvest—and tuberculosis is a weed of sluggish growth, the seed of which is sown, in most cases, during childhood, and takes root gradually during the teen age. Fortunately, in most cases the disease is checked in its seedling stage and never reaches the harvest.

### INCIDENCE AMONG COLLEGE STUDENTS

The school child of today is the college student of tomorrow. A considerable number of college students develop tuberculosis. To them, the disaster seems to come as a stroke out of the blue; actually the disease may have been present, potentially at least, during elementary and secondary school years. Examination of approximately 6,000 students in the University of Minnesota, made by the student health service, revealed 40 cases of manifest tuberculosis. A similar survey embracing 2,784 freshmen of several eastern colleges showed that about one out of each 200 of them had definite, though not in all cases disabling, tuberculosis. In Yale, the ratio for the entire freshman body was about one out of 55, and for the divinity students alone, about one out of 25. Among the medical students of the University of Pennsylvania, evidence of tuberculosis was found in the lungs of 4.2

*Presented at the meeting of the School Nursing Section of the New Jersey State Organization for Public Health Nursing, Camden, New Jersey, April 22, 1933.

per cent of freshmen, 11.6 per cent of sophomores, 13.9 per cent of juniors, and 20.4 per cent of seniors. That does not mean that all these students are consciously ill or incapacitated, but many of them undoubtedly will be if the warning is not heeded. Consider the wastage involved in the heavy investment necessary to train a student whose usefulness is curtailed or cut off by tuberculosis.

### WHAT CAN BE DONE TO LOWER THE TEEN AGE CURVE?

Adolescence seems to be the transition period between the seeding time or infection in early childhood, and the harvest time or manifest disease in early adulthood. What can be done in the school period to lessen the steepness of the death rate curve from age 15 to 25? Most essential is an *appreciation by school officials and teachers of the situation and a working knowledge of the biology of the disease.*

Tuberculosis is not hereditary. There is only one direct cause, namely, the tubercle bacillus, but several contributary causes, such as poor nutrition (in the broad sense), unwholesome living conditions, overwork, dissipation and lack of sleep. Infection by the tubercle bacillus takes place chiefly through close contact with a person who has the disease and who expectorates or discharges tubercle bacilli. The drinking of unpasteurized milk from tuberculous cows is a less frequent means of acquiring the disease. Once the bacillus has found a lodging place in the body there is a physiological response which, under favorable conditions, results in the formation of a tubercle or enclosing capsule of cells, which prevents the bacilli from spreading. At the same time the particular lymph glands draining the involved area also become infected. These two protective mechanisms, however, sometimes fail, especially in infancy, in which case the child may be overwhelmed by the enemy and quickly die.

Another physiological response to first infection is that known as allergy, which for our purposes, may be interpreted as a sensitization of all the body cells to the tubercle bacillus, causing them to respond more quickly to a similar infection thereafter. Space does not permit a detailed discussion of this phenomenon; it must suffice to say that in some cases this sensitization serves to protect the individual against further attack and in others, perhaps, to lead ultimately to destructive disease. Unfortunately, one cannot say in a given case whether the first infection will serve to "vaccinate" a child or develop ultimately into disease. For that reason, many tuberculosis specialists today regard every infection as a warning signal, if not a potential danger.

### THE DANGER OF REPEATED INFECTION

This early or latent form of the disease is hardly to be considered as a disease, for it seldom gives rise to symptoms or to physical signs. Only with the aid of the tuberculin test, which reveals that tubercle bacilli are in the body, and the X-ray, which under favorable circumstances, pictures the tubercle and the associated lymph glands, can the diagnosis be made. Just what causes the destructive form of disease to develop is not entirely clear. But the fact that activation of latent tuberculosis seems to take place so often in the late teens and early twenties, leads to the suspicion that at this period some influence causes the resistance to be weakened. Certainly it is significant that at this time children are subjected to strain —mental, emotional and physical. The restraints of home are thrown off; the urge of adolescence tempts the youngster to "burn the candle at both ends"; he competes for scholarship and athletic honors, he strives for social recognition, and he spends far too little time in sleep. But probably repeated infection is the most important factor determining whether or not a person will develop tuberculosis. Growing children who live in a tuberculous environment are likely to receive into their bodies repeated and large "doses" of tubercle bacilli. Since resistance to this disease is never absolute, such large dosages of tubercle bacilli are likely to turn the balance unfavorably.

How shall we protect the school child

against the disaster of destructive tuberculosis appearing in his college or early adult years? Obviously, the general community measures for controlling the spread of the disease, so carefully built up during the past three decades, must be rigorously practiced. Developing proper health habits and maintaining the nutrition of growing children are important, and these are obligations resting largely upon the elementary and secondary schools. *But that is not enough.* These wholesale measures should be supported by a more specific attempt to protect those relatively few who are presumably threatened with actual disease. Cases of latent tuberculosis do not proclaim themselves—they bear no obvious labels. Malnutrition is of practically no help in the selection of what we once called the "pretuberculous" child. The commonly known symptoms of tuberculosis, such as cough, expectoration and loss of weight are usually absent in the latent form of the disease. Fatigue, the most characteristic symptom of adult type tuberculosis, is not an uncommon danger sign in the early forms of the disease, but fatigue in youngsters may be due to so many other causes as to exclude it as an indicator of tuberculous infection or disease. Even when the disease has passed beyond the first tubercle stage and has begun destructively to invade the lung tissue, warning signs are all too rare. For example, among high school students examined in Detroit, 14 cases of tuberculosis of the so-called adult type were discovered, only two of which showed any physical signs.

### DELIBERATE DEFINITE SEARCH ESSENTIAL

Only by a definite search can latent tuberculosis be discovered. There are several ways of doing this. One plan is based on the extensive work done for the past six years in Massachusetts. It consists of giving the tuberculin test to all school children. Those who react positively are given an X-ray examination of the chest and a physical examination. Children who show any evidence of severe infection are followed up by the public health nurse in their homes to discover, if possible, the source of the infection. It is impossible to predict how many children of a given age group in a given area will react to the tuberculin test, or how many serious lesions one may expect to find, since each community varies in these respects. Some general idea, however, may be gained by reviewing the findings among the 200,000 children examined in Massachusetts as follows:

> Of each 100 children between 5 and 15 years of age, an average of 28 reacted to the tuberculin test
>
> Of these when examined by X-ray, 5 showed that some slight damage had been done
>
> But only about 1 of these five showed damage serious enough to require continued medical attention.

The advantage of this plan is that it saves the expense of making X-ray pictures of approximately two-thirds of the children for it is not necessary (in so far as the discovery of tuberculosis is concerned) to X-ray those who do not react to the tuberculin test.

In some places it is difficult to secure the consent of parents for the tuberculin test, especially if the test used is the intracutaneous method, which is done with a hypodermic needle. To overcome this obstacle some communities are now attempting to X-ray all children, omitting the tuberculin test. One manufacturer has devised an apparatus for taking X-ray pictures rapidly (at the rate of 100 per hour) on a sensitized paper roll. This roll is developed in its entirety and then mounted on reels on a viewing frame so that the interpreter may pass quickly from one picture to the next. This helps to cut the cost considerably. The paper film is cheaper than the usual transparent film and the staff of doctors and nurses reaches many more children.

### IF FUNDS ARE LIMITED

It is not always possible to carry out a case-finding program completely. In communities where funds are limited and only a portion of the school population can be tested with tuberculin and

the X-ray, the high school group may be selected, or the group may be limited to the senior class of the high school. In this older group a larger percentage of lesions are likely to be found than among elementary grade children, and furthermore, the senior year provides the best opportunity to employ group methods as described.

#### INDICATIONS FOR TREATMENT

Having discovered those children who are presumably in need of special care what can be done to protect them? Speaking in terms of the clinician, the "indications for treatment" for a child with the childhood type of tuberculosis are:

1. Contact with the tuberculous adult, who presumably has infected the child, must be broken. This is done by removing the tuberculous adult to a sanatorium, or by taking the child out of the home. If both of these expedients are impractical, every member of the household must be taught the principles underlying the transmission of tuberculosis and what methods to use in self-protection.

2. The child must be relieved of all possible strain, which means the avoidance of strenuous exercise and burdensome school work. Rest is the cornerstone on which preventive care is based.

3. The child's health must be built up, which means that all physical defects must be corrected and the benefits of good food, sunshine and fresh air must be made available.

4. The psychology of the child must be adjusted so that he will not think of himself as being inferior to others with greater margin of resistance, and yet will restrain over-ambitious impulses.

These indications for treatment can, under ordinary circumstances, be met without the aid of a special institution. The family doctor, understanding parents and a coöperative school administration are well able to render the care that a child with childhood type tuberculosis needs. But there are, of course, numerous "problem families," as the social worker calls them, where it is impossible to meet the requirements enumerated above. These problem families are not limited to the poor or ignorant, but include many of intelligence and means, which, for one reason or another, are unable to afford the child the protection which he needs.

#### PURSUING TREATMENT

While no concrete formula can be given for the solution of the problem, an understanding of the general principles should enable any community to work out its own solution and determine the type of preventive care which best suits its needs. Open-air schools and open-window rooms represent attempts to cope with the problem. Instead of emphasis on open air, as was once the case, there has been evolved a regimen of rest, supervised play and the promotion of good nutrition. These essentials can, with a little ingenuity, be worked out in almost any school without heavy expenditure.

Meantime we are learning that fatigue is one of the foes of all youths because it interferes with growth and development and invites disease of many kinds. Consequently the tendency is to plan the curriculum and the extra-curricular activities so that the capacity of the child shall not be unduly taxed. Also, we are appreciating that all children are not equal in endurance power and that we must be selective in assigning tasks. Our scheme of competitive athletics, for example, should be seriously scrutinized. The wise physical educator realizes that it is not fair to pit children of unequal physical capacity against each other—but how does he know whether or not a given child is handicapped with a potentially crippled heart or a dormant tuberculous focus that may easily be lighted up?

In my estimation the deliberate search for early tuberculosis in school children, though somewhat difficult and expensive, is well worth the effort. The special care needed by a small percentage of the children is not too much to ask for, for it consists only of those commonsense measures to which every child, under ideal circumstances, is entitled. The damage done by consumption can never be fully repaired, but it can to a large extent be prevented. The time to anticipate that disaster and to prevent it is during school days.

# The Effectiveness of Public Health Nursing Service for Rural School Children*

By MARIAN G. RANDALL, R. N.

THE measurement of results of school nursing activities has an added significance because of present changing conditions. The economic readjustment which this country is undergoing demands of health agencies that every dollar of public funds shall be spent with a higher degree of efficiency than ever before. As a means of bringing about this increased efficiency it is necessary to evaluate with unusual care the effectiveness of all public health procedures. These procedures must be tested by their results in attaining the aims they are designed to accomplish. As one of the principal agents of school health work, the public health nurse must be prepared to modify her program of work in order to secure the greatest possible results.

In planning for the most effective use of the available public health nursing service there are two points of primary importance: (1) a selection of the school children to receive service, and (2) a determination of what amount of service to the individual child is most profitable. It is usually not possible, and probably not practicable, to provide extensive public health supervision service for every school child. From the point of view of public health the distribution of services should be planned so as to attain the most needed results for the greatest number of children.

The question of what changes in practice should be put into effect to improve the quality of work and further accomplishment of results can be answered more constructively if we study the facts about what public health nurses have been doing, and to what degree they have been successful in attaining their objectives. As a contribution to the subject this paper summarizes some of the results of an analysis of the nursing services rendered to 2,048 rural school children with reported physical defects, in Cattaraugus County, New York. It is especially concerned with the experience in one phase of the school nursing service, namely, the nurses' visits to the homes as related to one objective, the correction of physical defects.

## SOURCES OF MATERIAL

Using the reports of the school medical examinations made in the 99 rural public schools in three nursing districts in Cattaraugus County in the academic year 1930-1931 as the first source of information, an attempt was made to measure the results of public health nursing activities in bringing about corrections of reported defects. For every school child in this unselected sample a year had elapsed since the date of the medical examination, and this twelve months is the period used when considering the nurses' home visits and the correction of defects. The information was taken from the nurses' records for a year following the date of the examination,** from the records of corrections reported from the schools, and from the reports of the examination the following

*From the Division of Public Health Activities, Milbank Memorial Fund, New York City. This is one of a series of studies on public health nursing in official agencies.

**In using nursing records as sources of material for analysis, a difficult problem is presented by the lack of comparable recording of the content of every home visit. If after the first visit the defect had once been recorded as a problem, it was occasionally assumed that subsequent recorded visits to the individual child within the period included this problem, unless of course a correction had been made. In preparation for the study emphasis was put upon the importance of recording the full content of visits. While searching the records the writer found all the problems fully recorded so frequently that it is believed that the figures used here closely approximate the actual practice.

school year. In one of these nursing districts additional information was obtained for a sample of 352 school children, from the records of the United States Public Health Service special study, and from several conversations with the nurse about the details of the family situations, their attitudes and their health problems, all of which affect the accomplishment of corrections.

In common with rural counties in New York State, Cattaraugus County has many small schools. The school health problem in Cattaraugus involves the supervision of 293 schools, of which 266 are rural and 228 one-room schools with a total school population of 14,000. Over 8,000 of these children live on farms, 30 per cent of which are on unimproved dirt roads, and in small villages scattered over an area of 1,343 square miles. The promotion of a school health program in a rural area having a decentralized system of public education necessitates a special county-wide organization. The coöperation with the County Board of Health has afforded an opportunity for a school health experiment within the County Health Unit in Cattaraugus County,* and the nursing service to school children is an important part of the coöperation between the Board of Health and the school organization. Again, from the point of view of the generalized program of public health nursing, the effectiveness of all the school nursing work is an important consideration, as it has occupied in the last few years approximately 33 per cent of the nurses' total time. In the distribution of actual field visits by the nurses, approximately 20 per cent were made to the children of school age.**

The number of home visits are commonly used to report field activities of public health nurses. In the twelve months' period there were over 1,270 visits made to 785 school children in the districts studied. The total school population in these districts was 2,843. The number of visits made may exceed the volume of work possible in most rural areas, and it far exceeds suggested standards such as those of the appraisal form for rural health work set up for experimental use by the American Public Health Association. With the standard of 200 visits per 1,000 school population, 568 home visits would have attained the full rating. But the accomplishment of results is the real objective. In relation to this particular problem, for example, the number of children visited and the number of children having defects corrected mean more than the total number of visits made.

### SELECTION OF CHILDREN FOR HOME VISITING

The amount of nursing service available for home visits to school children makes it necessary to select which children should receive these visits. Since analysis shows that a nurse in this rural area, in the course of a year, visits in the homes of about 180 school children and is able to make approximately 320 visits to school children, she is obliged first, to select which children are to be visited at all, and second, which children ought to be visited more than once.

The selection of which school children need public health nursing service is influenced primarily by the results of the school medical examination.† Of the total enrollment of 2,843 children in the schools studied, 2,048 or 72 per cent

*The organization and program of school health work is described by Dr. C. A. Greenleaf, director of the County school service, in a pamphlet entitled "School Health Work in Cattaraugus County," published by the Milbank Memorial Fund.

**During the year of this study there were two supervisors, a director of the Bureau of Nursing and an average of twelve staff nurses, each serving a population of 3,500 to 4,500. It should be remembered that this analysis relates only to a part of a generalized public health nursing service and that each phase of the service is influenced and largely controlled by the total demands of the health department program.

†This generally accepted means of discovering health assets and liabilities of the child is carried out in the rural schools of Cattaraugus County according to the New York State law which requires an examination of every child each year. It has been suggested that the County's original plan of an examination at the time of the child's entrance into school and then every three years would be an admirable procedure.

were reported as having one or more physical defects. The list of names of these children represents the nurse's potential home visiting problem. She is concerned, of course, with all things pertaining to the health and welfare of the child, but the correction of defects is one of the principal objectives of her school activities.

#### RELATION TO VISITING OF ECONOMIC STATUS OF FAMILY AND SEVERITY OF DEFECT

One basis of selecting which children with defects shall be visited is the degree of severity of the specific defect classified by the generally accepted practice of checking a defect as xx or xxx at the time of the physical examination. This is the physician's responsibility. His decisions can be of greater value administratively if he appreciates that in addition to an examination of the individual child, he is also carrying on a screening process to select which children are most in need of the limited public health nursing supervision available.

Another basis of selecting the children to receive follow-up visits is the ability of the parents to obtain medical or dental care for their children. This is reflected in the relative economic status of the families.

The relation of these two factors to home visiting to an unselected sample of school children is shown in Table 1 by the per cent of school children with defects *not* visited. For children with 2x defective teeth, 54 per cent in families of comfortable and moderate means did not receive follow-up visits, while only 27 per cent of the children in poor and very poor families with the defect of the same degree did not receive a visit from the nurse. For the children with 3x defective teeth only 18 per cent of the children in low income families did not receive a follow-up visit. A similar relation to selection is shown for children with defective tonsils. In the higher economic status 80 per cent of the children with a 2x defect were not visited as against 40 per cent in the lower economic group. For the 3x tonsils 46 per cent of the children in better circumstances were not visited, but only 15 per cent of the children who had defective tonsils in the poor and very poor families did not receive at least one follow-up visit from the nurse. All the poorer children with defects of the eyes received visits from the nurse.

The economic status of the family and the degree of severity of the defect are two factors which naturally operate.

Table 1. Per Cent of School Children of Different Economic Status with Defects of Specified Degree *not* Visited in the Homes by Public Health Nurses in Cattaraugus County

| Economic status | Per Cent not visited | | Number not visited | | No. having defect of specified degree | |
|---|---|---|---|---|---|---|
| | 2x | 3x | 2x | 3x | 2x | 3x |
| **Teeth** | | | | | | |
| Any status | 45.9 | 39.1 | 56 | 47 | 122 | 120 |
| Comfortable and moderate | 54.1 | 54.2 | 46 | 38 | 85 | 70 |
| Poor and very poor | 27.0 | 18.0 | 10 | 9 | 37 | 50 |
| **Tonsils** | | | | | | |
| Any status | 43.6 | 32.2 | 38 | 19 | 87 | 59 |
| Comfortable and moderate | 80.7 | 46.8 | 26 | 15 | 57 | 32 |
| Poor and very poor | 40.0 | 14.8 | 12 | 4 | 30 | 27 |
| **Eyes** | | | | | | |
| Any status | 56.2 | 42.3 | 18 | 11 | 32 | 26 |
| Comfortable and moderate | 85.7 | 68.7 | 18 | 11 | 21 | 16 |
| Poor and very poor | 0 | 0 | 0 | 0 | 11 | 10 |

but if there are some children with 3x defects in the poorer families not receiving visits from the nurse while other children with relatively less serious defects in better type homes are receiving visits, it raises the question of the advisability of using these two factors as bases of selection in further conscious planning for home visiting to school children.

In a generalized public health nursing program the selection of school children receiving follow-up visits for the correction of defects is also influenced by other problems in the family. In a sample of 352 children, 41 were an only child and 146 had no younger siblings. In only 12 instances were there adult problems in the family, 4 maternity cases and 8 tuberculosis cases, leaving 175 instances where the only problem was school children with defects. Only 68 of these children were visited by the nurse and all but seven received only one visit.

Repeated home visiting to school children with defects is usually combined with visiting the home for other problems. In only five instances for our sample of 352 children did a school child receive a second visit that was not combined with some other problem in the family and in three of these instances the nurse took the child to a physician or oculist because no other means of transportation was available. It is true that second and third visits were sometimes made because of the school child's defect but other problems were included. The most frequent example of this was to make arrangements for the children in lower income families to attend a special tonsillectomy clinic or to take a child into the city for a special examination after securing funds from interested groups in the community to make possible the needed treatment.

Table 2. Public Health Nurses' Visits to Homes of Different Economic Status and the Correction of Specified 2x and 3x Defects for a Sample of School Children in Cattaraugus County

| Nurses' home visits | Economic Status: Comfortable — No. with defects | Comfortable — Children with corrections No. | Comfortable — Children with corrections Percent | Moderate — No. with defects | Moderate — Children with corrections No. | Moderate — Children with corrections Percent | Poor and Very Poor — No. with defects | Poor and Very Poor — Children with corrections No. | Poor and Very Poor — Children with corrections Percent |
|---|---|---|---|---|---|---|---|---|---|
| **Teeth** | | | | | | | | | |
| Total visits | 33 | 12 | 36.3 | 122 | 43 | 35.2 | 86 | 12 | 13.7 |
| None | 13 | 6 | 46.1 | 71 | 25 | 35.2 | 19 | 2 | 10.5 |
| One | 19 | 5 | 26.3 | 42 | 13 | 30.2 | 35 | 6 | 17.1 |
| Two or more | 1 | 1 | 10.0 | 9 | 5 | 55.5 | 32 | 4 | 12.5 |
| **Tonsils** | | | | | | | | | |
| Total visits | 23 | 6 | 26.0 | 66 | 3 | 4.5 | 57 | 2 | 3.5 |
| None | 13 | 5 | 38.4 | 28 | 1 | 3.5 | 16 | 0 | — |
| One | 10 | 1 | 10.0 | 33 | 1 | 3.0 | 28 | 1 | 3.5 |
| Two or more | 0 | 0 | — | 5 | 1 | 20.0 | 13 | 1 | 7.6 |
| **Eyes** | | | | | | | | | |
| Total visits | 10 | 4 | 4.0 | 27 | 9 | 33.3 | 21 | 5 | 23.8 |
| None | 9 | 4 | 4.4 | 2 | 7 | 35.0 | — | — | — |
| One | 1 | 0 | — | 5 | 1 | 20.0 | 10 | 1 | 10.0 |
| Two or more | 0 | 0 | — | 2 | 1 | 50.0 | 11 | 4 | 36.3 |

## MEASURING RESULTS

To measure the results of the nurses' activities in relation to correction of defects is relatively simple inasmuch as the correction itself constitutes the positive accomplishment. Results, in terms of corrected defects, are shown in Table 2 for children in families of different

economic status. It would seem from the experience with this sample of children that visits are more needed in the poor and very poor families, as comparatively few of these children who were not visited had corrections. These families are usually without means of transportation and many of them live on unimproved roads at the greater distance from the health centers and from the offices of doctors and dentists. For cases receiving repeated visiting there was less increase in the percentages of correction for the poorer children than in the higher income groups. Undoubtedly, this reflects the limited facilities for providing care and the results are, therefore, limited no matter how frequently the nurse may visit in these homes. The seriousness of defective vision probably warrants greater effort in finding a means of obtaining treatment and the results are shown by increased percentage of corrections especially in the lower income families.

Table 3. Public Health Nurses' Home Visits to School Children in Cattaraugus County with One or More Reported Defects and Corrections

| Nurses' home visits | Children with one or more defects | Children having one or more defects corrected | |
|---|---|---|---|
| | | Number | Per cent |
| Total visits | 2,048 | 672 | 32.8 |
| None | 1,263 | 404 | 32.0 |
| One | 501 | 174 | 34.7 |
| Two | 156 | 47 | 30.1 |
| Three | 55 | 17 | 30.9 |
| Four+ | 73 | 30 | 41.2 |

### WHICH CHILDREN WILL HAVE CORRECTIONS WITHOUT A HOME VISIT

Another example of the relation of nurses' home visits to the accomplishment of results is shown in Table 3 for our larger sample of school children. Of the total of 2,048 children with one or more defects, 672 or 32.8 per cent had one or more corrections. There were 1,263 children who were not visited by the public health nurse and of this group 404 or 32 per cent had corrections. This 32 per cent may be interpreted as the per cent of children that can be expected to have corrections without the influence of the nurse's visit to the home. It represents the influence of health education in the schools, the interest of the teachers and other workers in the community and the percentage of parents sufficiently interested and able to provide medical care for their children. If upon receipt of the notice regarding the results of the school examination the parents would inform the teacher what they could or could not do about having their children's defects corrected, it would assist in telling the nurse *which* children would be in the expected percentage that would probably have corrections made. This would serve as one basis of selecting the children to receive home visits.

The accepted point should be mentioned here that visiting in the home is not, of course, the only method of bringing about the desired results. In fact, personal contact in the homes may be effective but it is an expensive method of health education which, when supported by public funds, should be limited to the point of maximum returns. Any other means of bringing about the desired results are to be encouraged. The parent's presence in the school at the time of the medical examination is obviously greatly to be desired. While parental attendance has increased steadily each year, rural conditions offer difficult problems and in the three nursing districts studied there were only 140 conferences with parents in schools.

Table 3 also shows that there was a total of 785 children visited one or more times. There is a slight increase in the percentage of children having corrections after one home visit by the nurse, for 174 or 35 per cent of the 501 children visited once had one or more corrections, as against 404 or 32 per cent of the 1,263 children not visited. Repeated

visiting does not seem to be related to increased percentages of corrections until four or more visits are made, and in terms of the accumulated service for relatively few children it is a question how far the increased amount of service is justified by the slight increase in results.

In the group not visited by the nurses the 859 children (404 subtracted from 1,263), who did not have reported corrections represent the extent to which the available services did not reach the existing problems.

only slightly higher in terms of per cent of corrections than after one visit.

For defects of the eye, 20 or 27 per cent of the 75 children visited once had corrections as against 4 or 36 per cent of the 11 children visited four or more times. If the four children in this latter group had serious defects, repeated effort on the part of the nurse to secure treatment, is wholly justified. It will never be advisable to overlook the individual in health work. On the other hand, from the point of view of the total problem and terms of the amount of

Table 4. Public Health Nurses' Home Visits and the Correction of Specified Defects for School Children in Cattaraugus County

| Nurses' home visits | Number of children | Children having defects corrected | |
|---|---|---|---|
| | | Number | Per cent |
| **Teeth 2x or 3x** | | | |
| Total visits | 1,191 | 236 | 19.8 |
| None | 718 | 137 | 19.1 |
| One | 293 | 62 | 21.2 |
| Two | 95 | 22 | 23.2 |
| Three | 34 | 4 | 11.8 |
| Four+ | 51 | 11 | 21.5 |
| **Tonsils 2x or 3x** | | | |
| Total visits | 827 | 72 | 8.7 |
| None | 490 | 35 | 7.1 |
| One | 210 | 21 | 10.0 |
| Two | 72 | 4 | 5.6 |
| Three | 22 | 3 | 13.6 |
| Four+ | 33 | 9 | 27.2 |
| **Eyes 2x or 3x** | | | |
| Total visits | 364 | 81 | 22.3 |
| None | 231 | 49 | 21.2 |
| One | 75 | 20 | 26.7 |
| Two | 32 | 6 | 18.8 |
| Three | 15 | 2 | 13.3 |
| Four+ | 11 | 4 | 36.3 |

The relation of nurses' home visits to the correction of specific defects is shown in Table 4. This experience shows that for these specific defects it may be expected that 19 per cent of children with teeth defects, 7 per cent with defective tonsils and 21 per cent with defective eyes will have corrections even if the nurse does not find time to visit in the homes.

For the correction of teeth defects the results after four or more visits were

service given, namely, more than 16 home visits, and in terms of the amount of service available, it may be justifiable to question the accomplishment of results. Would a greater number of children have had corrections if these 16 visits had been made to 16 of the children in the "not visited" group?

For defective tonsils there is a more decided increase in per cent of corrections for the children receiving four or more visits, but for many of these cases

these repeated visits were for the purpose of making arrangements for the child to attend a special tonsillectomy clinic set up for the purpose of providing this service for a group who could not otherwise secure the needed medical care. This raises again the question of the relative value of repeated visiting for the purpose of urging parents with very limited incomes to have children's defects corrected, unless the nurse can give information about and assurance of existing facilities for securing the needed care.

#### REASONS FOR FAILURE TO CORRECT DEFECTS

The reasons why defects are not corrected may be summarized from the parents' response to the nurse's effort to interest them in the reported need for care. While these "reasons" may not tell the complete story in every instance they are sufficiently accurate to be used administratively in determining the need for changes in practice. It becomes of interest, therefore, to know that in 68 out of 212 or 32 per cent of instances the parents refused outright to consider the need for treatment. These refusals were accompanied by statements of lack of belief in dentists and doctors or of discredit of the health department because of some previous unpleasant experience, such as quarantine measures and the like. In 56 or 26 per cent of the instances parents promised to consider having care. In some cases this served as a momentary excuse but in others corrections were really obtained in the year following the period studied. If we may classify these two groups as "ignorance" and "lethargy" they offer a challenge to the health workers and their methods of health education.

An especially significant group were the 48 or 23 per cent who replied that they were willing but could not afford to have corrections made. When it is obvious that these families really cannot afford to pay for care, a list of these children with defects represents the extent to which free facilities are needed to meet this problem.

#### ANALYSE RESULTS FOR GREATEST GOOD TO GREATEST NUMBER

Rules for frequency of home visiting must necessarily be flexible in order to be practical, but the results of experience and practice in relation to specific problems can serve as a valuable guide to bring about greater efficiency. Any public health nurse might object to a statement that repeated visiting in the homes does not bring about desired results, because she knows of cases in which the objectives were finally accomplished after considerable time and effort was spent in the home. This is undoubtedly true. But in which families were they? When she can answer the question "What were the circumstances which made additional nursing services advisable and profitable?" she has a basis for selecting the children to receive the amount of intensive service she is able to give. The nurse's interest in the individual child is one of the community's most valuable assets but from the point of view of public health she must also be concerned with bringing about the desired results for the greatest number of children. If the public health nurse, or her supervisor, takes stock of the *results* of home visiting to a sample of school children with defects, it might be interesting and profitable to try out an experimental plan for home visiting which would include (1) visits to the children with more serious defects in the families least able to plan for and to provide care for themselves, (2) repeated visiting only to those children who because of some relatively serious problem or defect need it most, (3) extension of some of the available nursing services to a greater number of homes.

# A Health Program in a Private School

By HELEN NORTHRUP KNAPP, R. N.

A SPECIFIC health program in a private day school, as in a public school, is decidedly an essential from the standpoint of the child in relation to the home and community, as well as a vital factor in maintaining the health standards of the school.

Included among the objectives of the program should be maintenance and improvement of health; recognition and control of disease; and health education.

### THE PRIVATE SCHOOL NURSE

Health work can be carried on to a certain degree without a school nurse in a private school, but in many schools the physician is not on regular schedule, and the teachers are confronted with a full curriculum. Therefore, it is a great asset to have some one on the staff whose primary interest is health. An alert nurse will observe any abnormal symptoms or unhygienic factors in the environment and will try to find and eliminate their causes as well as cope with immediate conditions. The nurse's value is realized most keenly when she succeeds in obtaining the interest and cooperation of the teachers and pupils in the consideration of health in relation to all the daily activities.

The school nurse as well as the school doctor should be particularly careful not to interfere in any way with the function of the family physician, since most of the pupils have their own physicians, and should aim to coöperate fully with all suggestions made by him.

Assisting the school doctor with examinations and keeping accurate records are comparatively minor duties of the school nurse in the light of the innumerable opportunities afforded each day for the improvement and maintenance of the health of the students. Some of these opportunities will be found in the daily routine, others will be sporadic.

The school entrance requirements may well include the family physician's report, a complete physical examination by the school physician, and intelligence tests for determining the approximate I. Q. of the pupils. Tests revealing the tendencies toward emotional instability and maladjusted personalities would no doubt be helpful.

### EXAMINATIONS

The annual Fall examination by the school physician should include a detailed physical examination covering heart, lungs, throat, height, weight, nutrition, vision, hearing, posture and feet. Pupils with defects in the latter may have photographs taken for future comparison and be assigned to special corrective classes, with their parents' permission. Any undue nervousness or bad habits and mannerisms should be noted and the cause investigated.

In the Spring there should be a check-up on defects observed in the Fall. Photographs of the posture and feet may be retaken at this time.

Monthly examinations should be made of pupils with defects in vision and hearing when they have not been seen by a specialist as requested.

School lunches can be regulated and special dietary care recommended for those who continue to be under or over weight.

Any new health problem reported by the teachers or Physical Education Department should be considered immediately and recommendations made.

### RECOMMENDATIONS TO PARENTS

Following any examination when an abnormal condition is revealed which needs further attention, and after each Fall and Spring examination, a letter may be sent to the parents with a report of the physical condition of the child and the recommendation that the pupil be taken to the family physician or spec-

ialist whenever necessary. At the same time a slip may be enclosed to be filled out by the examining physician with the findings and treatment suggested by him. This should be returned to the school and placed on file for reference.

### COMMUNICABLE DISEASES

Any abnormal sign or symptom such as coryza, skin eruptions, etc., observed by the teachers should be reported to the Health Department of the school immediately and the child excluded from classes until seen by the school or family physician.

When a positive diagnosis of a communicable disease is made either at home or by the school doctor, the child should not be allowed to return to school without the written sanction of the family physician.

All of the intimate friends or the pupils in the same class who are immune and who were exposed at school during the incubation period should undergo an examination by the school physician before class every morning during the time they would show symptoms. Exposures outside of the school are subject to the same rules regarding examinations, but the examinations are arranged by the family. This is not the responsibility of the school.

Each child undergoing the examination should be forbidden contact with any other classmate until after he is pronounced symptom-free and given a slip to enter the classroom for that day. This daily inspection will prevent the necessity of quarantining all the children exposed to measles, mumps, chicken pox, and German measles (except members of the same family, who are definitely excluded from school). Whooping cough, scarlet fever and diphtheria exposures require definite exclusion.

The School Physicians' Association of New York City has drawn up regulations which are followed by many private schools.

Each parent may be supplied with absent slips to be filled out with the length of time and reason for the child's absence. This slip should be presented to the school nurse or teacher before readmission to classes.

During the day the nurse may go to the classrooms and obtain the list of absentees. At this time she may have a brief conference with each teacher and any health problem can be reported and discussed.

After a child has been absent three days, if the school authorities have not been notified as to the cause of absence, the nurse may call the home by telephone and obtain the desired information. This precaution is particularly valuable in relation to any possible development of a transmissible disease.

### FIRST AID

Under this heading may be considered all the conditions for which children are referred to the Health Department. This would include treatments of common ailments such as headaches, foreign bodies in the eye, epistaxis, etc., as well as minor injuries sustained in the carpentry classes, gymnasium or playground.

*Prevention* is the basis for all treatments and no matter how insignificant the condition may seem, the children should be encouraged to report it at once. If the cause is an accident, it may be possible for the nurse to take steps at once to avoid a repetition of the mishap.

### GENERAL HYGIENE AND SANITATION

The arrangement of seats so that the children are not facing the light and the placement of electric fixtures to relieve glare are important health considerations. Adjustment of the seats to the proper height is a pertinent aid to better vision as well as posture.

Proper lavatory facilities with individual towels and drinking cups should be provided.

A Board of Health examination for any of the personnel directly handling milk or other food is required.

An adequate ventilating system may help to prevent respiratory infections. As an example of this the Health Department of a private school in New York City noted after carefully exam-

ining records that a considerably larger percentage of absences was caused by colds and upper respiratory infections than by other conditions. In an effort to determine the cause, an expert on ventilation was asked to examine and make a constructive report of one room having a particularly high rate of colds among the children. His recommendations were carried out and there was a 4% decrease in colds the following year in the same room under very similar conditions.

### HEALTH EDUCATION

If there is no health teaching included in the regular curriculum, many health habits can be encouraged and health information introduced concurrently into the child's daily activities by the teacher at the suggestion of the school nurse. There are many opportunities for correlation of health projects with the routine programs, such as health posters and sketches in Art; health books and oral and written health stories in English; health habits of foreign children in History and Geography, etc. It can be suggested that the children confined at home with minor illnesses make health scrap books and submit them to the nurse, the best to be kept in the Health Office.

### COOPERATION

No matter how constructive a health program may be, it can prove beneficial only insofar as coöperation is received from the parents, the Physical Education Department, the teaching staff, and from the children themselves. Ideally, the nurse should have a conference with the mothers at regular intervals, even when there is no particular problem to be discussed. A more thorough understanding of the reason for extra precaution in the prevention of transmissible diseases will reconcile the mother to the practice of sending a child home when a definite symptom of a cold is observed, or when there is even a slight elevation of temperature.

The work of the Physical Education Department is so closely correlated with that of the Health Department that one is as important as the other in building up a successful health program in the school. Because of this, close coöperation between the school doctor and nurse with the Physical Education supervisor and instructors is a vital requirement.

Teachers' meetings afford splendid opportunity for discussing the health of the children in relation to their progress in the various classes. Any reactions deviating from normal should be discussed in relation to the cause. It is often found that undue retardation in studies is the result of fatigue caused by over-stimulation from so many extra-curricular activities popular with the private school group, such as dancing, music lessons, fancy skating, horseback riding and swimming instruction. For this reason a record of each pupil's activities outside the school should be kept on file for reference.

The teachers have the most intimate contact with the students and are in the best position to observe any abnormal symptoms. By sending the child to the Health Department for examination immediately when a questionable condition presents itself, they aid greatly in eliminating many possible complications. Very often they give valuable suggestions as to how to approach the child in relation to his health problem.

### RECORDS

A record of practically every factor regarding the health of the child may be kept in the Health Department. In a folder for each child should be the record of examinations, duplicate copies of reports and recommendations to parents as well as any communication from them or from the private physician in relation to health. All reports of examinations and treatments recommended by the family physician or specialist should be kept on file. A communicable disease record, including the report from the parents following each summer vacation, may also be included in this folder. This routine information should be particularly beneficial in the immediate determination of the immunity of each child when a new case of transmissible disease is discovered.

Dates of vaccination against smallpox and immunization against diphtheria may be noted, as well as operations, injuries and susceptibilities, such as asthma, migraine, fainting, menstrual difficulties, etc. Photographs of posture and a checked list of extra-curricular activities may also be filed in the folder.

A record of absences with causes furnishes an extremely valuable source of information in determining percentages of absences due to various conditions and shows the total number of school days lost by all the members of the school, as well as by individual and class. Interesting graphs can be drawn from the records to show conditions and trends by the month and by the year.

A copy of the report of the activities of the Health Department should be filed before sending the original to the principal's office each day. This detailed account will aid in keeping the school authorities in constant touch with the health of the pupils as well as the daily accomplishment of the department and will facilitate writing the monthly and yearly reports.

#### A PROMISING FIELD

By obtaining the confidence and arousing the interest of the pupils in the various means of improving and protecting health, one has a splendid foundation on which to build a constructive set of sound health habits. Their vivid imagination proves very fertile ground on which to work, and certainly no subject in the curriculum is more important than the health of the school child. As stated by Dr. Lucy Porter Sutton, School Physician for one of the large private schools for girls in New York City: "The school is primarily interested in education, but the education of the child with physical or psychological handicaps is difficult and the child is therefore definitely prevented from deriving the maximum benefit from the educational advantages offered by the school."

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## SCHOOL CHILDREN FOR LUNCHEON GUESTS

Our experiment of extending the hospitality of our homes instead of following the usual program of providing hot lunches in the schools in Holliston, which is a Branch of the Framingham, Mass., Chapter, has proved not only successful but gratifying. When the plan was suggested, we formed the Sunshine Dinner Club among interested housewives with the purpose of inviting into our homes to share luncheon with us children forced to carry cold lunches and be away from home many hours.

The program has had the cooperation of the parents, the teachers and the school nurse, so it could hardly fail. When it started to function many questions were raised. We were asked: "How long will parents and individuals be willing to continue the work? Will parents object to their children eating meals in various homes? Will the children hesitate to come to table among strangers? Will the teachers participate in extending invitations and assist in placing children?"

Our fears proved groundless. Members of the club and parents who have had the children at luncheon, at first perhaps for one day a week, have in many cases had their little guests with them two or three times and some even every school day. They have in almost every instance continued through the school year.

We have learned that the parents have been grateful and pleased. A week after the children had received invitations to have lunch in different homes, one parent came to present a dozen eggs to the committee as an expression of appreciation, the gift going to a family whose undernourished children required eggs in their dietary. We learned, too, that the children are happy to join a family in the home for the noon lunch. They express their appreciation in various ways, some by a desire to be invited again, others by offering thanks to a hostess on leaving for school, and still others by joyous description of the happy time enjoyed in a friendly home.

Our teachers have noted the beneficial effect, finding that the children had overcome the lassitude apparent at the end of the morning session and were more attentive and keen at the afternoon session. The walk to a home and back to school, the hot meal, the change of environment, the teachers declare, have induced real improvement in mental and physical attitudes and in deportment. The teachers are enthusiastically in favor of continuing the program.

*—Mrs. William R. Byrne in The Red Cross Courier.*

# First Aid As It Affects Nurse or Teacher Load

HAROLD H. MITCHELL, M.D.

*How can first aid in the schools be made an educational procedure? Below is an actual conversation on this question between a school administrator and a school physician.*

FIRST aid service generally adds materially to the load of duties carried by the school nurse. The variety of demands upon the nurse's time calls for a constant adjustment of the nurse load if an efficient school health program is to be attained. Likewise the teacher load is another adjustment that is constantly before the school administrator not only in relation to the health program but in the interest of the whole curriculum. First aid as well as other health services have been shifted in most schools from the teacher to the nurse whenever possible. This relief for the teacher load has seemed reasonable, and it may be efficient when the nurse can carry out the service and educational objectives desired by the school. When the shift of a service from the teacher to nurse fails to provide adequate service and when there is a loss in the educational influence upon the child, then the relief for the teacher load should be balanced against loss in service, loss in educational influence and burden upon the nurse load.

Much has been said about coöperation between the health and educational personnel in a school health program. Since the adjustment of teacher and nurse load involves administrative policy and an understanding of the whole school program, the school administrator should of necessity be taken into council with the director of the health service. The health service director functions most effectively as an advisor who makes clear the objectives of the health program, and how they may be carried out most effectively.

The following account of a discussion between a principal of a large urban school and a school physician illustrates how the burden of first aid to the nurse and the teacher may be adjusted when frank discussion leads to mutual understanding.

The physician had spent the morning in the office of the nurse, and the principal asked him for a frank criticism of the procedures observed. As past experience assured the physician of the principal's sincerity in requesting a candid opinion the physician asked:

"Is first aid training an objective of your curriculum?" The principal replied that it was.

"Do you believe children should learn to protect themselves against infection from cuts and bruises, or do you think they should learn to depend upon a nurse for such protection?" was the next question.

"First aid for cuts and bruises is taught in our hygiene course. We don't teach them to depend on a nurse," replied the principal.

"What I saw in the nurse's office this morning suggests to me that your children are learning to depend on the nurse rather than to take care of themselves," was the blunt comment of the physician.

"What do you mean? What did you see?" asked the puzzled principal.

"I saw a great influx of pupils into the nurse's office for first aid treatment of minor cuts and abrasions received on the playground or in school. I saw no teaching of first aid by the nurse. I learned that the nurse rarely makes an attempt to teach first aid because she feels the necessity for administering it as rapidly as she can. The responsibility upon the nurse for the follow-up of many physically handicapped children

causes her to give a preference to the follow-up service over the teaching of first aid."

"Yes, I know we need more nurses. If we had the full time of a nurse for this school then she could teach first aid," was the principal's ready solution.

"I am not so sure that more nurses could solve the problem," replied the physician. "It would hardly be economical to have a nurse on duty all the time for first aid. Although you have a large school, the nurse was not continuously busy on first aid this morning but it does seriously interfere with her other duties. If she were always available for first aid, such service would interfere with her getting into the classrooms, and it would certainly interfere with her assisting the physician, interviewing parents, and with home visiting. Furthermore, don't you consider the teaching of first aid is more a problem of pedagogy than of nursing?" the physician asked.

"No doubt the teachers know more about teaching than the nurse," said the principal, "but the nurse knows a lot more about first aid."

"I would not recommend that the nurse give up all first aid duties. Emergencies may arise when she should be called on to act directly whenever she is available, but the bulk of the first aid and particularly the prevention of infection in cuts and abrasions is of such a simple nature that any intelligent mother can and does do all that is necessary. Why not teach the children to perform this simple first aid for themselves? Of course you would agree that they will learn more by doing than from lessons in a textbook."

The principal recognized that first aid is an experience that every pupil must learn through actual doing. As an educator he was as much concerned about the proper teaching of first aid as in the protection of the children against infection of wounds. The principal and physician discussed the importance of learning to apply iodine or other suitable skin antiseptics promptly to any break in the skin in order to prevent infection and the desirability of learning to cover an open wound with aseptic gauze. How to preserve an aseptic technique and how to hold the gauze in place with adhesive or a roller bandage were recognized as skills to be learned through experience. The principal's knowledge of the learning ability of pupils in different grades led him to recognize which classes were ready to acquire these skills. He pointed out that the youngest children could learn to ask promptly for the antiseptic and to apply it under the teacher's direction. He said that a fifth or sixth grade child certainly could learn to apply aseptic gauze and fix it in place according to the location of the wound. He recognized that the habit of doing the right thing to prevent infections must be acquired through the activity when the situations arise, and that the small accidents of the playground and classroom provide the teaching materials both for habit formation and for training in skills. As a teacher the problem of the kind of instruction needed was clear. But the educator was also an administrator, and he was concerned with the interruption of the geography lesson to teach first aid. He liked the neat arrangement of sending the child to the nurse for first aid. If the teacher's instruction was confined to the hygiene period, it fitted regularly into the curriculum. First aid instruction given when an accident occurred interfered with school routine. But the educator preferred good pedagogy to preserving the administrative routine. He raised the question of how first aid equipment could be made available. Must he have an outfit for every classroom? If it was kept in the nurse's room how was the teacher to obtain the equipment without interfering with the class work? The dilemma of the administrator was clearly a choice between ideals of teaching and the smooth working of administrative machinery.

The dilemma was discussed and it was agreed that the educational objectives desired for first aid required some sacrifice in the administration of the curriculum. The teacher load was heavy and the interruption for first aid would burden the teacher to some extent, but the principal accepted habit training in

first aid as an important objective of education. He had seen the readiness with which the children acquired both the habit and the skill in wound protection in the manual training class where the equipment was kept readily available. It seemed reasonable to him that the children could soon learn to take care of themselves under the teacher's direction without too much interruption of the work of the teacher. But such equipment in every classroom loomed as a prohibitive expense.

"How much equipment is needed?" he asked. "Couldn't we keep an outfit in my office and let each teacher send for it as it is needed?"

The last suggestion provided the means for prompt treatment to prevent wound infections, and at the same time an opportunity for the teachers to make their first aid instruction vital without too great expense or burden upon necessary administrative routine. A small box with skin antiseptic, sterile gauze pads in sealed envelopes and two sizes of roller bandage, adhesive and scissors were suggested as adequate material for carrying out this simple procedure. Through discussion at teachers' meetings the problem was presented from all sides, and the teachers were quick to grasp the significance of the project and pledged their coöperation. The nurse was more than willing to demonstrate simple first aid procedure to those teachers who requested it.

The teacher load was no less a problem to this principal than to most administrators. First aid instruction was truly an objective of the curriculum, and a recognition of how this objective should be attained became the deciding factor in the principal's decision. No question of preference for the nurse or the teacher in lightening their load entered into the decision. The question was entirely one of how to attain the objectives of education and service economically and efficiently. When both the health advisor and the educational administrator see the problem together from that standpoint is there any need for disagreement?

## "BALANCED BUDGETS AND UNBALANCED LIVES"

"In a phase of economic crisis, there are interests that lie beyond economics, and, unless these interests that have to do with the bodies and minds and spirits of the men and women and children of the nation are safeguarded in the midst of crisis, economic recovery itself will prove a barren achievement. It is quite as important to balance the nation's life as to balance the nation's budget. It is quite as important to prevent a social deficit for the future as to wipe out a financial deficit in the present. . . There are at least five fundamental rights, long recognized and repeatedly stated by realistic schoolmen, which the public has in its schools.

(1) The public has the right to understand the character and cost of its schools. Schools must take the mystery out of their budgets and translate their statements of educational aims into the vulgate so that what they are driving at and why it costs what it costs can be understood by taxpayers to whom the accounting terms of business offices and the technical jargon of pedagogues are all too often but so much Sanskrit.

(2) The public has the right to an education it can afford. We do not live in Utopia, and, by virtue of this fact, the public has the right to say what kind of education it can afford at any given stage of its socio-economic development.

(3) The public has the right to an education fitted to the nature and need of individual students. With thundering hordes of students crowding into our schools, it is difficult at best to keep from factoryizing education. To trim budgets to a point where it becomes impossible to do other than present a table d'hote curriculum and herd students into large lecture halls for shotgun discharges of information, hoping some will be hit, is a bad investment of public money.

(4) The public has the right to have its sons and daughters taught by teachers who love teaching. The right of the public to teachers who love teaching carries with it the obligation to invest the teaching profession with a decent respect and remuneration.

(5) The public has the right to have its schools administered efficiently and economically."

Excerpts from an address by Dr. Glenn Frank to the Superintendent of Schools Advisory Council, April 7, 1933, at Chicago, Illinois.

# Evaluating the Home Visit*

By RUTH BENSON FREEMAN, R.N.

IN judging the effectiveness of work done in the home visit, it was found very difficult to set up any standards or measures of expected accomplishment. Standards of work must of necessity be influenced by many factors in the community and in the individual or family. The amount of teaching, the kind of coöperation received from the family, the facility with which bedside care may be given will all be modified by the economic and intellectual levels, the nationality, the customs or *mores* of the group in which one works. Even in a rather small urban area, we find a great variety of home conditions, ranging from a group afflicted with dire and hopeless poverty, coupled with high death rates and disease susceptibility, to a group which, though still in the low income level, has high standards of health and family life. Illiteracy and superstition also decrease the rate with which we can progress with health teaching. We must, therefore, set standards which will be flexible enough to meet these varying conditions, and strive toward a practical ideal rather than the sometimes impossible theoretical one.

Sometimes, when there is too great a conflict between our ideals and those already held by the family, compromise is necessary. This is frequently true when the conflict arises over customs or traditions. It is very difficult to persuade the sorrowing wife in some nationality groups to dispense with an elaborate funeral in order to provide more for her fatherless children. There is very likely to be an elaborate procession with plumes and a band on one day and an appeal to a charity organization the next. And mothers who have all their lives believed that the restricting *fascia* will insure a straight back for the baby, are not going to give up the idea readily. If we feel these traditional reactions are harmful, it is necessary to use discretion in combating them, and perhaps we must compromise in order to preserve a good contact with the family and keep our chance for further health teaching. I can remember my own expression of horror when I first learned that small children were given coffee, and my righteous indignation at the mother who allowed it. Yet perhaps it would have been wiser had I progressed a bit more slowly, maintained my sense of proportion and my good contact, and been willing to compromise a bit instead of expecting the family to conform immediately to my standards of healthful diet.

### CONTENT OF HOME VISIT

With due regard for the need of an open mind and practical standards of achievement, the content of the home visit may be considered from three angles—the attitudes set up between the nurse and the family, the content of the visit, and the use of available tools for increasing the effectiveness of the visit.

The attitudes which the nurse sets up in the family she visits influence greatly the amount she is able to accomplish. A "good contact" is a necessary prelude to an atmosphere of trust and understanding between the nurse and the patient which makes for an effective visit. Without it, the best of technical skills, knowledge or interest is wasted.

The art of making good contacts is one which can be cultivated. There are certain little "tricks of the trade" which make an easy approach possible, and most of these are found to be based on an ability to see the other person's point

*This material is the result of a staff conference held at the 79th Street Branch of the Henry Street Settlement Visiting Nurse Service in New York City. The article was compiled from notes taken during the conference, and as far as possible follows the general course of the discussion.

of view. Such a thing as making very clear who we are, what organization we represent and our reason for calling, is an ordinary courtesy which might easily be neglected when there is much work to be done and little time in which to do it. Conscious attention to questions which bring good response will also result in an easy approach: asking about the children, showing some interest in the method or problems of housework, asking whether this is a convenient time to call—these questions usually provoke friendly and interest-gaining responses.

If behavior can be conceived as the expression of an emotional need, it will often be much more understandable. If, when faced with intolerance, arrogance, or deceit, we can forestall our own response of indignation and try to see the reason for this behavior, we are often able not only to understand it, but to prevent its recurrence. Everyone functions in an environment of physical factors, habit patterns, and social precepts which influences greatly what is done and how it is done. One of the nurse's jobs is to recognize the environment in which her patient or family is functioning, and when unfavorable environment cannot be changed, help them to adjust to it as adequately as possible.

The content of the visit should include giving to the patient and the family a feeling of satisfaction in having needs met, as well as the teaching or advice we wish them to have.

#### THE GOOD EXAMPLE OF BEDSIDE CARE

A great many of our clients ask for active bedside care. It is absolutely essential that the nurse be able to give this in a careful, orderly way, using the standard techniques which have been devised to protect the patient, herself and the community. Merely by example, the nurse who gives good bedside care will teach many little niceties and devices which will enhance the comfort of the patient. She is filling adequately the outstanding need of the family as it sees it and so establishing firmly that good contact which was started when she made her first entrance to the home.

#### THE ART OF TEACHING

The importance and need of bedside care cannot be minimized. Yet this is not an end in itself, but should act as an effective wedge in opening the way to health teaching. The value of this teaching should be judged by: the extent to which it is adapted to meet the needs of that specific family situation; the care with which it is planned to utilize the experience of the patient and lead smoothly to new ideas and the degree to which it is consecutive and comprehensive. No one teaching plan can be utilized in every situation, and the extent of knowledge displayed by a nurse is not always an index to her effectiveness as a teacher. The mother who has yet to learn the benefits of rudimentary personal hygiene will rarely benefit by even the most brilliant of expositions on the dangers of bad behavior patterns in children. Nor is the mother who has a bare maintenance income interested in optimum diets which she cannot afford.

Teaching should be comprehensive but not overwhelming. In a visit to an expectant mother it is wiser to emphasize one point at a time, e. g., the essentials of an economical and well balanced diet for herself and her family, than to try to tell her all about the supplies she will need, the clothing she should wear, the mental attitudes, signs of abnormalities and prenatal hygiene in general. Careful planning will show where emphasis should be put in teaching, and the amount of teaching which should be done on each visit.

If every member of the family is included in the health teaching, the visit is a much stronger one. Teaching Johnnie-four-year-old to hang up his own clothes might include: securing his coöperation, promoting the mother's understanding of the need for habits of orderliness, enlisting the aid of father or older brothers in providing a place for Johnnie to hang his clothes on hooks low enough for him to reach. This sort of teaching sticks much better than a

casual "You should make Johnnie hang up his own clothes."

### RECORDS

Adequate recording affects the quality of service rendered in the home. The primary purposes of records are, of course, to insure accurate interpretation of doctor's orders, to list treatments given, condition and progress of the patient, and to act as a basis for study of community needs. Accurate and complete records protect and make service easier. They insure continuity of service when a different nurse visits the home. If in addition to this report on the treatment and progress of illness, the record gives us a picture of the environment in which the individual is functioning, its present problems and the plans of family and nurse for meeting them, and a consecutive record of progress in teaching, then it becomes invaluable in guiding our work in the home, and in judging the value of work already accomplished.

### KNOWING WHERE TO TURN FOR HELP

The third factor in enhancing the effectiveness of the visit is the use of available resources and, indirectly, the nurse's efforts toward self-improvement. The use of other agencies in the district, supervision as provided in one's own organization, participation in group activities and group thinking, and professional and non-professional reading, all contribute to more effectual service and to the growth of the nurse.

Intelligent use of every available community resource is necessary if a visit is to do all the good possible. The first essential in intelligent use is an accurate knowledge of these resources—information about the private doctors of the district, exact hours and days for clinics, addresses and names of workers in social agencies. The second essential is to choose the right agency, and to refrain from doing something for which another organization is responsible. The third essential is to give a clearly written note of reference which will serve to introduce patient and agency, and explain to the worker why the referral has been made. This wise use of other agencies not only accomplishes more for the patient, but strengthens the contact with the family, establishes the position of the nurse in the community more definitely and cultivates community consciousness on the part of both patient and nurse.

### SUPERVISION AND SELF-IMPROVEMENT

Supervision, wisely used, increases the value of the home visit. In a field visit the supervisor brings in a fresh viewpoint, and can often give a new interpretation to a situation. She can help the nurse to evaluate her attitudes and aptitudes, and show how professional knowledge and techniques may be adapted to the home situation. She may have had broader experience or special training which can be utilized in strengthening the home visit.

These benefits of supervision imply a democratic spirit and frankness on both sides. The nurse, as well as the supervisor, should be prepared to discuss freely the work done in the homes. She should be ready to ask for supervision not only when she can show good work accomplished, but also in cases where she feels she has failed. This means a little courage and trust on the part of the staff nurse, but is one of the best ways of increasing the effectiveness of field work. The nurse, through office consultations, should share her knowledge and problems of the district with the supervisor. The doctor who does not understand the service may be won over by the joint efforts of the staff nurse and supervisor in interpreting the service to him. Sharing the planning for a difficult case might result in more effective work, and save many futile efforts.

The nurse can also increase her effectiveness in the field by participating in staff plans or staff meetings. Group discussion not only helps in clarifying her own ideas, but makes formulation of new techniques or policies a truer interpretation of the needs of the district, for the staff nurse is closest to the community. It also promotes an alert attitude toward current happenings and

possible changes which may result in increased service or better visits.

### WITH THE AID OF THE PRINTED WORD

The value of reading, both professional and non-professional, cannot be overestimated. Reading about what someone else is doing stimulates thought, keeps one aware of constantly changing ideas and ideals, and often yields concrete ideas which may be used in the home visit. Statistics, when viewed in the light of families in a definite area, may be fascinating. What are the problems of a particular district as revealed by the death rate? What nationality groups are served? Do they have particular problems? How would the extremely high tuberculosis incidence among Puerto Ricans affect the care given to a post-pneumonia Puerto Rican? All these leads are to be found in rather dry-looking statistical reports. They also show changes in the needs of a given area, or perhaps progress made through increased health care or legislation.

Non-professional reading might include everything from the daily newspaper to the latest modern novel—and should, if it is at all possible. It helps the nurse herself to become a broader and more interesting person. It also gives her a picture of the social milieu and forces which have a direct bearing on the work she is doing day by day. Methods of dealing with the unemployment crisis certainly influence the nurse's work. The constantly growing theory that radical changes in our entire social structure are inevitable before adequate relief can be assured is deserving of serious thought. Modern biography and fiction have much to tell us about the social media in which we are functioning, and may help in understanding people and their difficulties. Even the tabloids have their value as an expression of the thoughts and needs of many of our people.

Everyone evaluates our work—particularly as it appears in the home visit. Patients, supervisors, directors, community, city, state and nation—all are interested in our work. But perhaps the most worthwhile evaluation is the one we ourselves make in a conscious effort to better our visits. We must set standards for the home visit, but they must be flexible and practical. We must judge our visit as impartially as possible, considering it from the standpoint of the attitudes we have set up, what the visit has accomplished, and what use we have made of available resources for insuring optimum care. Such a consideration of the home visit, made periodically, should be a measure of progress and professional growth, as well as a guide for further effort.

# Checking High School Absences

By HELEN MURRAY, R. N.

*A good example showing how a routine procedure in the school program can be put to constructive use, of benefit to the student, the nurse, and the school.*

WHEN a child is well, the proper place for him is in the classroom during school hours, and when ill, at home. In the high school I believe the absentee problem is far greater than in the grades, mainly because of the difference in the age of the students. The attitude of the high school student is far different from that of the grade school child who comes to school because he knows it is the thing to do and because he fears the disapproval of his parents and teachers. There is very little of this fear left by the time the high school is reached; on the other hand, there is the opportunity to reach the high school student through reasoning and through instilling an appreciation of the value of education as preparation for the future.

After six years of experience in the Baldwin (N. Y.) Public Schools, I think that the absentee records have improved, especially among the high school group. We feel that our present system of dealing with high school absentees is working well, and is contributing not only toward better health, but also to the improvement of scholastic work through the "make-up plan".

Our high school building is open at 8:15 A. M. to students, and classes start at 8:30. I am in my office every morning at 8:05 and usually do not leave until 9:20 for the grade schools. Our attendance in the high school is 1293, and in the grade schools 1596. Our rules for attendance are the same for all registered pupils regardless of the legal age limit, which is 7-16 years inclusive.

Six years ago I used to wonder how I was going to find out anything about the causes of absences among the high school boys and girls. There seemed to be no way that a nurse with six schools could do it through the office without spending altogether too much time. Therefore, I asked the principal if all those absent could come to the nurse's office for their excuses. On a 3x5 card I keep a record of each student absent, dates, and reasons by code (*i. e.*, c—cold, st—sore throat). At the end of the month it is not difficult to find out how many have been absent and the reason. This is not the only good feature in the absentee parade to the nurse's office. At this time those returning have an inspection, and if for any reason it seems not advisable for a pupil to remain, he is sent home before entering his classroom, thus protecting him and others from further illness.

From year to year changes have been made in this system. We have a percentage of 97.5 attendance for the year 1932-33; in 1931-32 the percentage was 95.5; in 1928-29, 93.3%. The senior high school students returning after an absence report to the nurse, the junior high school students go to the health teacher, who sends on to the nurse any she feels need the nurse's inspection before being admitted. A legal pass on white paper is given to those with a written legal excuse. Blue passes are given to those with a written illegal excuse, or to those who return without a written statement from home. This pass may be changed if a written statement is brought in later. The New York State Teachers' registry code is used on the admittance pass—Legal: S—sickness, F—family sickness or death, Q—quarantine, C—religious observance, Co—required to be in court, R—weather; illegal: O—unlawful detention, ——truancy, X—illegal employment. This code is used by the home room reacher in recording the reason for the absence in the register. The pass must be signed by each teacher, and left in the home room at the end of the day.

At a high school health council meeting in January, 1933, I suggested making a closer check on all who had been absent 4 days or more due to colds. The total number for this reason was 112 from September, 1932, to February, 1933. The doctor and dentist gave this group a special examination. The following defects were found: Tonsils 7, acne exaggerated 1, overweight 1, heart 2, tuberculosis contact (family) 2, dental 54. One interesting fact was noted—of the 112, 60 had previously had tonsil operations. A letter notifying the parents of the fact that their child had been absent 4 days or more due to colds, and telling of the existing defect, was sent home. We asked their prompt attention and coöperation in obtaining correction of the defect. Almost without exception the recommendations were carried out and the necessary treatment given.

A similar letter will be mailed at the close of school to all parents whose children have been absent 5 days or more due to colds, sore throats, headaches or digestive upsets, urging a physical examination and correction of defects during the summer months.

Our present system of checking has been found the most effective that we have tried. The make-up work is in charge of a senior high school teacher whom the students respect. Each pupil absent must report to this teacher at the close of the first day that he returns to school, and either remains with her, or, on the presentation of a pass, may study with another teacher. Each must prove by the presentation of a card that he has completed the work missed during his absence. This, of course, entails constant checking and rechecking, and the success of the system depends on the coöperation of the teacher.

Only 4% is deducted from the mark of each student illegally absent, or for any absence where no written excuse is brought in, providing that the work is made up. The majority of the high school students are quite concerned about the credits being deducted. Although we were rather dubious at first as to the outcome of the plan of student detention, we find that the students do not seem to feel this a punishment, and we try to make them see that it is a privilege. We truly feel that the boys and girls are concerned enough about their personal hygiene to try to keep well and attend school. We also feel that very few are coming when ill.

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## A GOOD SUGGESTION

In examining school children why send a note home to the parents only when there are defects? Why not also when the child is in good condition? This has been tried in several places with excellent psychological effect on the parents. For example—"John was examined by the school physician today and was found to be in excellent physical condition. You are to be congratulated on the good care you are giving him and trust that you will continue it." Can't you just see the parent swelling with pride at this; and also the envious glances of neighboring parents whose children *had* some defects, and the subsequent scrambling on their part to get the defects corrected as soon as possible?

This is one of the many valuable points brought out in the Health Education Conference held in Ann Arbor, Michigan, in June, under the auspices of the American Child Health Association.

# A Public Health Nurse Looks at North Dakota*

By GENA M. JOHNSON, R.N.

IT is our good fortune to live in a great rural State—North Dakota—and the problems that confront us are very different from those of the visiting nurse in a crowded city. The very vastness of our prairies, and the magnificent distances that separate our rural communities bring new and different problems, arising not from congestion, but from isolation.

The conditions in this "bread basket of the world" have been in many instances most unfortunate this year, due in some measure to the wonderful fertility of our soil that has produced such an abundance of food stuff, the world has not been able to assimilate it. There is a stagnation of markets for these products resulting in hardship in a material way for our people that has crippled industries and schools and embarrassed the very existence of our old established usages and customs.

Health, in spite of these hardships, has never been better. People have shown a courage in the face of the catastrophes that have piled upon them that is almost beyond belief. There seem to be some reasons for this period of good health. In the more prosperous years in which we lived easily, and worked and played with abandon, and took no care for the morrow, our habits of living and our very freedom of motion brought us epidemics and claimed the lives of those with resistance lowered by fast living and overeating. The last year or two have brought about a change. People are sobered and serious, and are working industriously at home to solve the problems that have suddenly threatened to overwhelm them. It is the most opportune time for our profession to be of service. The problems of actual want, the conditions that accompany near-starvation in this land of plenty, the need of underfed children, unbalanced diets, lack of sufficient clothing, and of course, illness—are but a few of the problems we have been called upon to meet in these recent years.

### DANGER SIGNALS

I am impressed with the fact that the resistance of our children is slowly running down. The symptoms of malnutrition are becoming more and more numerous and we must be more zealous than ever to institute such preventive measures as we have at our command, if we are to keep our children free from diseased conditions that are sure to come upon them now when they are least able to cope with them.

It has been the object of our health unit this year to impress upon our school officers the fact that the need of preventive measures has never been more urgent. We have conducted a vigorous campaign for the immunization of pupils against diphtheria, and have met with considerable success. It is to be regretted that we have not been able to make our immunization 100 per cent, but we have made very great progress, and the education of the parents in these preventive measures has been very encouraging. Yet we have today a sleeping giant in our midst, one that will awake to his might and deal death if we cannot arouse public interest. I refer to smallpox. It has been many years since we have had an outbreak of smallpox in North Dakota and the public is not "smallpox-conscious." They seem indifferent to immunization against this disease. It looks as though it would require a very grave outbreak, and possibly some loss of child life, to

*Paper presented at the State Health Officers meeting, Bismarck, North Dakota, May 2, 1933.

bring the importance of this oldest preventive measure to popular attention and action. Some of our parents have been circularized with a vicious pamphlet describing the horrors and wickedness of vaccination. It will require much patience for us to overcome this false propaganda. Immunization against smallpox has, in some of our communities, dropped to almost nothing. In some of our schools, the lower three or four grades have few, if any, pupils vaccinated.

It has been disappointing to me during the past few years to note the surprising amount of dental caries encountered in our yearly inspection of pupils. I am sure that the daily attendance records of hundreds of pupils is influenced by this one thing alone, for a child with a toothache is not a good student, and the peridental infections that are found lead me to believe that many of our sick children would return more promptly to their school work if the parents took a more active interest in their children's dental health. Fruits and fresh vegetables, needed for tooth health as well as bone growth, are being sidetracked and other articles of food substituted, either because of the carelessness and lack of knowledge on the part of parents, or as a matter of grim economy. The simplest farm has the fresh vegetables and leafy plants which, properly prepared, will grow healthy bodies. It is a matter of education, and it should be the prescribed duty of every public health nurse, when the undernourished child is found, to visit and instruct the mother in the proper management of her child's dietary, calling attention to the presence of dental caries, malnutrition and other conditions that arise out of improper feeding.

### ARMING AGAINST THE ENEMIES

Some of our grave systemic conditions are assuming alarming proportions. Juvenile tuberculosis is gaining on us in this State. It is necessary that we be ever watchful to detect quickly and take precautionary measures against this menace. The public does not treat this condition with indifference, but is intensely interested. It shows that our teaching is bearing fruit. But I have found that the pendulum has in some instances swung to the other extreme. The unfortunate tuberculous patient has been treated as a social outcast. Fear of the disease must be routed through understanding. Our attention must be centered now on the undernourished child who does poorly in school, is always tired, perhaps runs an afternoon temperature. These cases must be caught in time and we must never forget that one case comes from another—and to find the other!

The major diseases, especially the acute exanthemata, are more readily detected in the schoolroom than in the home, and the watchful teacher should detect the symptoms promptly, take the temperature, and send the child home. Every schoolroom should be equipped with a clinical thermometer and the teacher taught how to use it, for few of the acute contagious diseases come on without some rise in temperature, and early detection of this rise safeguards the whole school. The feverish child should be sent home promptly, and told to call his physician. There may be a few false alarms, but the system in the main is to be commended.

Juvenile diabetes is encountered with greater frequency than ever before, possibly due to the fact that it is being recognized more readily than formerly. The child that without apparent reason seems to be losing ground, should seek the counsel of the family physician early. The results are gratifying in most instances. Authorities differ as to the exact etiology of this disease, but opinion leans toward dietetic deficiency of some variety. Surely the parent of a diabetic child needs most exact information as to the proper conduct of the child's diet in order to keep him comfortable and actually prolong life. The use of insulin can be taught readily to the intelligent mother and an explanation of the chemistry of this condition given, under the close supervision of

the family physician. We have a number of diabetic children in our county that are handled in this manner. It sometimes becomes a major problem to finance daily doses of insulin, but our school authorities have been generous.

The secondary anemias are found commonly, and pallid faces, pinched cheeks and decreased weights are the aftermath of influenza, tonsillitis, and the communicable diseases. The parents are only too prone to return these children to school too soon with the idea that they will overcome the condition without help. This is a mistake. These children need all the attention available to build up the resistance that disease has torn down. Long hours of quiet sleep, undisturbed by the radio, nutritious and wholesome food regularly eaten, plus tonics prescribed by the physician, will contribute to the prompt return of the depleted hemoglobin. I must mention also the secondary anemias and chlorosis, found in girls of high school age that call for the special attention of the physician. I am glad to see our high school girls returning to more sensible customs of dress, and the blue, chilled, underclothed bodies of a few years ago are not so common. The rage for a so-called "willowy form" seems to be passing also and the children lean more to the development of firm muscles and the "athletic build."

Tonsillitis is, and always has been, a disease of great frequency. It continues to be one of the major causes of school absence. Where there seem to be frequent and severe attacks of this disease, or if the tonsils are chronically enlarged and the crypts filled with exudate, the child should be referred to the physician. It is to be regretted that many of the children thus referred and recommended for operation are not taken care of. They are especially fertile ground for all kinds of infection, and parents should be urged, even at some sacrifice to themselves, to follow the recommendations of the attending physician.

Skin diseases, like the poor, we have always with us. Scabies and the disfiguring impetigo are almost a daily problem. However, the skin diseases will bring alarm to the parent more quickly than many other conditions, and with proper treatment are quickly overcome. In every school we find children whose home life is not ideal, cleanliness of the skin and clothing is not insisted upon and these children become a source of infection to a whole school. It sometimes requires stern measures and a large fund of tact to sort out and clean up the chronic carriers of these skin diseases. Coöperative work among the nurse, the pupil, the teacher, the parents and the physician is the only successful method of eliminating this unfortunate condition.

### A MORE INSIDIOUS FOE

I must speak of another situation, mentally unhealthy, which I have noted recently among our high school girls. They are reading unwholesome literature and in many homes this is not frowned upon, but rather encouraged. The public magazine booths are crammed with vicious stories, thinly veiled under suggestive titles, which offer filthy and degrading ideas. I believe that when we can, it is highly necessary to help the growing girl or boy select clean reading. I do not believe that it is outside of our duties as public health nurses to include some special attention to this evil when we find it prevalent. Unclean thoughts have no place in clean bodies.

I would also agree with those who are disturbed about the character of the radio broadcasts in the children's hours —the "bedtime stories." Innocent fairy tales have turned into wild stories of hair-raising adventure, in which children are at the mercy of brigands, thieves and kidnappers. The child is kept at a fever pitch from day to day wondering what will happen to his favorite. The evening meal is disturbed, sleep is troubled, and little minds are restless and anxious. There is no question but that all this is upsetting to the children, and is reflected in the nervous system. A concerted effort on the part of the great radio audience to express its dislike of this type of program to

the broadcasting companies would help to put an end to it.

I have tried to touch on the more important phases of our work as servants of the Public Health Department in our great State. Ours is a tremendous task. We are the connecting link that brings the ailing child to the sources of alleviation that modern science offers. We must overcome the prejudices of uninformed parents, the suspicions of the public, the indifference of the press. The most successful public health nurse is the one most well informed herself, most patient with the foibles of the public, most tactful in overcoming prejudice against the principles of sanitation, personal cleanliness and right habits of living. Our responsibility cannot be taken lightly. Children's lives are in our keeping, and who can tell how these future makers of America will look back and judge the care we have given them? Will they point with pride to our ceaseless diligence or silently chide us for our lack of interest in their well-being, when their need was most vital? It is my hope that the future generation will be able to say that we used what information we had to the limit, and will be able to point with pride to our effort to start them out in the world with clean wholesome bodies, unhandicapped by physical or mental defect. This would indeed be ample reward for our work.

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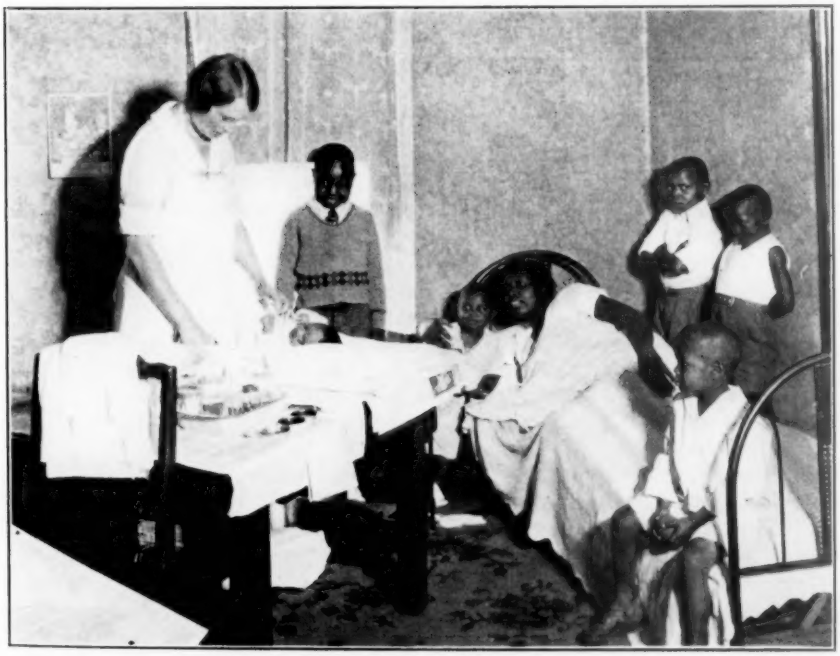

*At last, a baby sister!*
*An unusually successful group picture used by the Visiting Nurse Association of Saginaw, Michigan*

# Nurse-of-the-Month

## HANNAH A. JETER, R.N.

### Virginia

Miss Jeter is a graduate of St. Elizabeth's Hospital School of Nursing, Richmond, Virginia. She began her public health nursing work in Warren County in 1931. Previously she had worked as a clerk in the State Bureau of Vital Statistics and had become interested in health work through her many contacts with field workers in the Bureau. She entered training with her heart set on rural work. She writes the accompanying account of one of the popular pieces of work in her county.

The gentleman standing beside Miss Jeter in the picture is Mr. B. J. Hillidge, Mayor of Front Royal and the Chairman of the Warren County Health Association since its beginning seven years ago. Mr. Hillidge is also Chairman of the Warren County Chapter of the American Red Cross.

### CATCHING THEM YOUNG IN WARREN COUNTY

June is the month of roses, it is said—roses and babies; and this is certainly true in Warren County, Virginia, where every country roadside is hedged with pink petaled wild roses and many a visit to a preschool child introduces a new baby to the service.

This County seems to be reaping its rewards from the school nursing of the past seven years. This State has a five point program: teeth, eyes, throat, ears and weight must be normal or corrected to as nearly normal as medical service can achieve. Smallpox vaccination is compulsory and therefore not included; most of the school children have been immunized against diphtheria, but that is not a requirement. However, it is interesting to note that this Spring the immunization clinics closed with not only every school child immunized in two of our three 100% Five Point schools, but in the community of Rockland school which has been a 100% school for seven successive years, a survey showed every child from six months to fifteen years to have had toxin-antitoxin. Every beginner in this school attended the clinic and was examined by a physician and vaccinated and given toxoid if he had not previously received these two immunizations.

The preschool survey was made by the primary teachers. A letter from the Division Superintendent of Schools was sent to the parents of each requesting attendance at the clinic nearest the school and giving the date and the name of the physician in attendance. The beginners were invited by the teacher to visit the school on that day and were entertained in the classroom. They were weighed, measured, and the history taken on the physical examination card by the teacher—birth certificates checked or ordered from the Bureau of Vital Statistics if not on hand.

The clinics closed with about two-thirds of the number reported in the survey examined, leaving the nurse the summer months to visit the homes and urge corrections where needed. June saw these visits begun and the parents are much

interested in having Johnny and Mary enter school as five pointers next September.

In less than seven years from now we hope the babies discovered on these visits will check up as "five pointers" at the preschool clinics and require fewer corrections because one-third of the time of the nurse is spent in maternal and infant hygiene.

Another feature of our County is that all eighth grade girls are required to pass an examination in Home Nursing before entering High School. This class was conducted this year for the first time as a class for credit and this too, we hope, will make for healthier and better preschoolers in the future.

HANNAH A. JETER.

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# Public Health Nursing in Old Greece*

## I

## TEACHING HEALTH IN THE REFUGEE CAMPS

*Telling how the Greek people opened their doors to over a million refugees and provided shelter, care and a health program—a big job for a little country.*

ONE of the great refugee camps near Athens is the subject of this article. These refugee camps are groups of many thousands of people who came into Greece almost overnight, one might say, fleeing from the disasters of war in Asia Minor in 1922. There were over a million of these unfortunate people; families separated by death, by deportation, by being lost from one another in the terrible mêlée of those ghastly days. They had lost practically everything they had.

On coming to the motherland, which was also in stress from war, homes had to be found for these sufferers and quickly. The result has been that vast settlements have been built all over the homeland. It has taken years to do this and millions in money, and even yet it is not all finished. Some of the original barracks are still occupied by these unfortunates and stand today almost as they were in the beginning—the same long rows of small rooms, now getting old and shabby. As the families have grown, they have become increasingly crowded. It is in these places that gallant Greece could do with a bit of help—in fact, ought to have help.

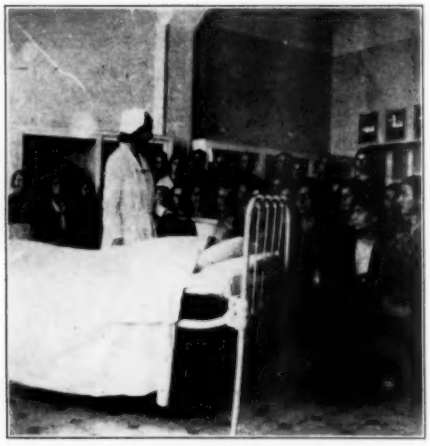
As every social worker knows, it is just such overpopulated, underspaced districts that governments, local and national, recognize as being potential danger spots, and where they encourage real efforts in rehabilitation. In one such place, Kaisariani, in the southeast section of Athens, the Near East Foundation began in 1930, what has matured into an excellent demonstration of education against disease.

*A day nursery in the refugee camp*

*See "Public Health Nursing in Jugoslavia" in May and June PUBLIC HEALTH NURSING; "Public Health Nursing in Poland" in July.

The fight against tuberculosis (Greece's greatest tribulation) at Kaisariani is described here. Tuberculosis infection in this country is very heavy, one in seven being afflicted. The underlying cause of this has undoubtedly been economic, for the suffering and deprivation of these refugees have been deep and terrible. But there are many things one can do about it. Really on last analysis, it appears that a very great proportion of infection comes from not knowing what to do to keep from getting the disease or from not recognizing it when it is in its first and curable stages.

A very obvious help in incipient cases of infection in our camp is the school feeding which is given in the great school of the settlement. Of 620 children the first year, 393 were given supplementary feeding. Last year the number was 205. This meal is served in the attractive, sunny, three-room basement



*A class in Home Hygiene—the same the world over*

of the school, built by the Greek Ministry for this work. A hot meal of protective foods, emphasizing vitamin A, is given in the middle of the day. The children are taught the hygiene of eating—cleanliness, order, leisure—with the result that many tuberculous glands are being reduced and much deficiency is vanishing.

Quite naturally, some people here only wish to flee this horror, not knowing how to live safely with it or near it. We established an examining clinic for a certain section which was surveyed carefully as to house and human infection. The very poorest who are infected or are contact cases are given cod liver oil and milk. The whole listed population can come to the clinic whenever the need arises. A doctor comes three mornings a week for examinations. He prescribes milk as he would medicine, also cod liver oil. In the summer when it is too hot to take the oil, phosphates and syrup iodotannic are given.

The clinic goes on every day from 8 A. M. to 1:30 P. M. Examinations are made by X-ray and clinically. Many depleting diseases have to be dealt with —intestinal parasites, malaria, etc., because these pull down the resistance of our people so that they easily become prey to tuberculosis. No medicines are given for these ailments but prescriptions are written and very definite instructions given to the mothers and fathers.

### TEACHING THROUGH CLASS AND HOME

The heart and soul of this project is its teaching. Mothers and girls are always instructed individually as they come to the clinic, but the afternoons are given over to group instruction. Since the beginning of this work, three thousand women have attended our classes. The same lesson runs through a whole week so that any woman who misses a session one day can come another time. This eases the strain and disappointment of losing lessons which might easily discourage some who feel they are getting behind and so drop out. They do not drop out!

Our text has been the American Red Cross textbook on *Home Hygiene and Care of the Sick*, which was translated into Greek and published by the Near East Foundation in 1931. This invaluable book is full of fine material for just such demonstrations as we need and has proved of tremendous interest and uplift. We have also used the United States Government pamphlets as texts. Many of our women cannot read or write; but they are bright and de-

sirous of learning and very apt with their hands. Each lesson is studied in great detail so that no step in the process can be missed.

In the evenings ultra violet ray treatments are given in the clinic rooms. This, with the sun, keeps many people from breaking down and we can show many, many cases of arrested tuberculosis.

Every day the latrines of the camp are treated by a small amount of borax so that today we have scarcely any flies —those awful harbingers of disease.

### STUDENT EXPERIENCE

In June, 1932, the School of Hygiene Visiting Nurses began sending students to Kaisariani for a month's training. Another nurse from the school has been appointed permanently to supervise this work. These nurses are instructed every day in the problems found in the camp. Three times a week the doctor instructs them on the technical and medical aspects of the work. The nurses come in twos. Besides helping with the clinic work and getting acquainted with methods of examination, they do home visiting to see how the women follow out the things they are taught and advised to do. Between two and three hundred visits are made during the month. All are written up and discussed at the end of the class period each day.

It is now a far cry from the time when we first began our work here, when people shouted at our doors and pressed upon our windows until they broke. Now there is quiet and order. The people appreciate our help and show it by doing what they are taught; and today we look upon a changed Kaisariani.

*A home visit by doctor and nurse. The hammock is lined with boards to keep baby's back straight*

ALEXANDRA ANTONIADOU.

Miss Antoniadou graduated from the American Hospital in Constantinople in 1924. Since her return to Greece she has been working with the Near East Foundation.

## II

## PUBLIC HEALTH NURSING IN CORFU, GREECE

The small island of Corfu is situated in the Ionian Sea just south of Albania. It has a long history. Named Korkyra (the tail) by the Corinthians in 734 B. C., it fell successively to the Romans in 228 B. C., the Oriental Empire in 336 A. D., the Neapolitans in 1267, and a century later to the Venetians. In 1808 it was taken by the French and in 1814 by the English. Now it is Greek.

The population of slightly over 100,000 is 95% Greek and largely agricultural in character. The only city, also named Corfu, has but 35,000 inhabitants, although it is the center of commerce. The chief products of the island are olive oil, wine, citrus fruits and figs. The farmers are inclined to be bitter and rather fatalistic, for the living is far from a sumptuous one. The maximum revenue per person per month is given as 150-180 drachma. (Less than $3.00.)

When one considers Corfu as an agricultural country, it is hard to believe that the actual diet is usually one-half pound of bread, wild herbs, often without salt or oil, and very little cheese, fish or meat about once a week and in very poor families three or four times a

year. School children receive a piece of bread in the morning and that is all until evening. With such an undernourished youth one cannot wonder that tuberculosis and malaria take their toll. Perhaps a delightful climate and sunshine compensate somewhat.

### THE NURSES COME

Such was the situation when the public health nurses started their work. We have had more than gratifying results.

The eagerness with which the people of Corfu have conformed with the measures undertaken and put in action by the Health Center gave us, even on our first home visits, the impression that this population was endowed with a very pliable nature, quick to understand and appreciate how the aim in general public health is beneficial to the group.

Our first undertaking was a campaign against the mosquito, as malaria is rampant in these districts. We made house to house visits studying the hygienic conditions in which the inhabitants lived and at the same time gave them advice and a few practical lessons in the means of checking this plague.

Besides this we are occupied with the problem of trachoma, a very widespread disease in the Corfu region, especially among the school children. Three stations have been opened for diagnosis and treatment, one in Corfu itself and the others on the outskirts in Mantouki and Garitza. In these centers the treatment is given under the direction of specialists. Frequently as many as 100 to 120 patients come daily for treatment. At the same time the nurses visit the patients' homes to track down new cases and advise concerning prophylaxis. Above all we insist on the patients following the treatments regularly until they are completely cured or at least cease to be infectious to others.

In the school hygiene work our efforts are also fruitful. We visit the families in which there are school children with some organic lesion which needs to be followed up and treated. We give at the same time advice as indicated by the Health Center and make every effort to check the progress of the bad beginning.

Unfortunately, we cannot report as much progress in tuberculosis. The lack of sanatoria, hospitals and preventoria, as well as the means to better the social conditions in which these unfortunate people live, oblige us to confine ourselves to giving advice only. However, the welcome accorded the nurses has been most kind and the eagerness to listen and follow our advice so unexpected that we are encouraged and filled with hope that one day our efforts may be crowned with complete success.

P. VRINIOTOU.

Miss Vriniotou is one of the public health nurses sent out and trained by the Hellenic Red Cross and holds the position of Instructor in the Corfu Health Center.

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### AT THIS MOMENT

By Arthur Guiterman

*A hundred thousand fishes are flashing through the deep,*
*A hundred thousand kittens are curling up to sleep,*
*In every blessed country beneath the arching sky,*
*At least a million children are busy asking "Why?"*

—*The Parents' Magazine, June, 1933.*

# Administering School Nursing on a Generalized Basis

*This article is a very brief summary of the experience of 13 city departments of health in carrying on a school nursing program on a generalized plan.*

WHEN school nursing is administered in an urban community on a generalized basis, i.e., a nurse carries on school nursing in combination with her other work, how does the nurse arrange her day's or week's work? How much time is given to school nursing? Is this plan satisfactory to the schools and to the nursing agency? Is it more or less economical than when administered on a specialized basis? What are the advantages and disadvantages of the plan?

These questions were sent recently to twenty city departments of health throughout the country which included school nursing on a generalized basis in their public health nursing program. Of the fourteen replying one stated that they did not administer school nursing in this way, but on the specialized plan. Thirteen were most generous in answering our questions and describing their program.

For many years county nurses in rural communities have taken it for granted that school nursing should be a part of their generalized program and have so carried on their work. In the cities, however, school nursing has been administered traditionally as a specialized service under boards of health or boards of education. Whether it can be administered efficiently any other way is a moot question, and one that may take years to decide. We do know that there is a definite trend today, due largely to the economic situation, toward an amalgamation of public health nursing services in a community. We also believe that a school nurse is essentially a public health nurse offering a public health nursing service. Whether these two factors will in any way influence the future development of the school nursing program remains to be seen. In the meantime, it is interesting to find that there are as many as thirteen and perhaps more city boards of health which are conducting a school nursing service on a generalized plan.*

Two of the agencies are in cities having a population under 50,000; five cities have between 50,000-100,000; and six have over 100,000 population, the largest being 1,200,000. Of the thirteen at least five include the parochial schools as well as the public schools in their program, one offering the service to the parochial schools only.

### THE NURSE'S SCHEDULE

In the majority of agencies the nurse visits the schools in her district daily spending anywhere from one hour to a half day in the schools. Two or three stated they were able to limit the number of schools in each nurse's district to two or at the most three, while one agency tries to have each nurse carry not more than 1,500 school children. Another agency definitely stated that their ideal is to have one school per nurse.

One agency was able to give an entirely satisfactory service visiting the schools routinely once a week with additional visits as needed. In one agency even a monthly visit to the schools has proved of value.

The nurse's schedule as given by one agency may be of interest:

*For description of one plan see PUBLIC HEALTH NURSING, September, 1931, "A Generalized City Health Service."

"All schools are visited daily. The nurse reports at a regular time to the school where students are seen at her office. Teachers desiring conferences either leave note for same or arrange to see the nurse during her school office hours. Slips for second day absence visits are given the nurse before she leaves the building. Practically no time is wasted—principals and teachers know when to expect the nurse and plan to keep nurse only as long as necessary. . . . . The schedule of a nurse carrying a Junior High and two grade schools is approximately: Jr. H., 8 to 8:45 A. M.; Grade School No. 1 (usually in same or adjoining building), 8:45 to 9:30 A. M.; Grade School No. 2, 9:45 to 10:30 A. M."

After the morning's work in the schools the afternoons are devoted to home visits for infant and child welfare, school, tuberculosis and communicable disease work. The amount of total time devoted to the school nursing program including time in school and outside of school ranged from 46% to 75%, one agency stating that 4/7 of the nurse's salary was paid by the Board of Education for that approximate amount of time spent on the school program. One agency writes:—"It is impossible to give the exact time spent on school work as each service extends into and is partly absorbed by the other services, as is also the cost in a generalized program."

### THE SCHOOL PROGRAM

What does the nurse do in her visits to the school? Assisting the physician at the physical examinations seems to be an accepted part of the nurse's service and she usually arranges her program in order to be present. Inspecting pupils sent to her by the teacher, checking on absences, conferences with teachers are included. Here is a description of one program that seemed to be particularly well thought out:

"The public health nurse supervises first aid equipment and procedure (which is, of course, outlined and under the direction of the district health officer) and the *teacher* gives first aid. Weighing and measuring is a part of personal hygiene work and teachers report to the nurse "failures-to-gain". Public health nurses and other supervisors have access to growth charts, observe and discuss changes in individual children with the teacher. While nurses do not conduct personal hygiene classes regularly, they may give public health interpretations to the teacher or the class. At times, much so-called school work is done in the homes; for example, when a home is released from quarantine, admission permits are given. Also, much of the exclusion or admission inspection is done in the home or health center, and it has never been our practice to schedule early morning inspection hours at schools for the purpose of admitting absentees.

"The general physical inspection of the individual child for which a health and development record is made is conducted in the school by the nurse, and such children as need a physical examination are referred to their own physician or to the school child conference. The parent or responsible person must accompany the child for this examination. General physical inspection by the nurse is made for grades one and five (also grade eight, if possible), new children from all grades and children who have been on the "watch list" from former years. Two courses per year in child growth and development have been given for teachers and prospective teachers (by a member of the public health nursing staff) for a period of years and this has helped to develop a broader conception of health activities."

Another agency writes:

"Care must be taken that school nursing is not confused with attendance officer or visiting teacher functions. Everyone concerned, including principals and sometimes even the nurse herself must be taught that the nurse has a program which must be covered during the school year and that she is not in the school solely to care for minor injuries, illnesses and other emergencies. These activities are a part but only a part of the whole. The nurse should be interested and show her interest in every school activity, but only as they involve her own objectives as a public health nurse should she permit them to consume her time and energies. Clerical work must be reduced to a minimum. Volunteer service from Parent-Teacher Associations and others increases the nurse's output and her influence."

### OTHER SERVICES—EVEN BEDSIDE

What other services beside school nursing are usually offered by the agency and how does the school nursing program fit in with them? While one of the thirteen agencies offers only one other service besides the school nursing, infant welfare, the program of the majority includes infant and preschool welfare, communicable disease, and tuberculosis; and three of the agencies include bedside care, two of them even offering a delivery service.

"But how can a nurse carry a bedside program and be at her appointed school every morning?" is a question that is frequently asked. Here is the way one

agency manages it with each nurse carrying two schools:

"The nurse reports to her first school at opening in the A. M. Junior High Schools are visited first. For her routine work she remains usually from an hour and a half to two hours. Then she visits her second school, spending from one to one and one-half hours. . . . . Between schools the nurse calls into the main office for district calls. If an emergency call comes in or a call that needs to be seen in the A. M., the nurse often leaves her second school early. She can always plan to work in one or two calls in the A. M. We have one nurse who serves as a floater and helps out for early morning calls in all districts; also we have two districts with rather light school and district work and these nurses are definitely assigned a case load, prenatal, postnatal and acutely ill patients in adjoining districts which are heavy."

As the director of this service has remarked, there are very few calls which are really "emergency" calls as such, and new calls coming in during the morning when the nurse is at school can be visited first thing in the afternoon.

"Not infrequently a mother will call up the main office and say—'May I have the nurse? My baby is sick. I know the nurse is at school now, but can she get in right after lunch?' "

Another agency says: "In our plan of work the nurse reports to her school at 8 A. M. unless she has a nursing visit to an acutely ill patient or a new maternity case. As much as possible the nursing district is the same as the school territory, and the principal and faculty understand and appreciate that when the nurse is not in her office at the opening of school she is in the home of one of the pupils."

Unfortunately when it comes to a comparison of costs between the specialized and generalized plan there are practically no figures available, although one or two of the agencies are studying this question at the present time. The majority of them, however, feel that the generalized plan is the more economical of the two, pointing out the savings in overhead, equipment, etc., in having one staff instead of two.

### RESULTS

But while it may be a more economical way of administering the service, do the results justify this plan? Are we getting economy at the expense of service rendered? These agencies think not. While a few express the wish that they had more time to give to the school program or more staff for the purpose, without exception they feel that it is satisfactory both to the schools and to the health departments. One school superintendent stated that to him the advantages of the generalized program are:

(1) The material contribution made to the family and the child before the child enters school.

(2) Under the generalized program there is continuity of method of handling from the prenatal or infancy period on; at the time of entering school there is no break in relationships.

(3) This method gives a single program to present to coöperating agencies, particularly the Parent Teacher organizations.

While in that same city the health officer feels that:

(1) With one directing head we have a better coördinated city wide program.

(2) We have better control of communicable disease.

(3) There has developed in the city a more wholesome respect for the health department and its functions than is found in communities where health activities are divided in different groups.

### ADVANTAGES AND DISADVANTAGES

The advantages emphasized most frequently by all the agencies in addition to economy are as follows:

(1) The service can really be a family health service which is the underlying principle of public health nursing.

(2) It means the continuity of service to the individual from the prenatal period through school and after.

(3) It prevents duplication and overlapping of work.

(4) One nurse visiting the home is more satisfactory to the family and to the nurse and makes for better health teaching.

(5) The communicable disease program is greatly strengthened.

(6) It is easier to interpret one service to the community than several.

(7) It makes possible a more unified city-wide health program.

Several agencies spoke of the advantage of such a plan to the nurse herself in broadening her field, combining as it does the community services with the

educational group. One agency mentioned the value of having the nurses work on the eleven-month plan, instead of the school year, thus giving them the summer months for follow-up work and preparation of children for the fall.

While the majority of the agencies felt that the disadvantages were negligible, one or two mentioned the fact that it was easier to get funds for supplies, etc., for the school program when the service was under the board of education. City funds, which had to cover the entire nursing service, were limited. One agency, in which the salaries of the nurses were partly paid by the board of education, felt that this involved certain difficulties in administration since each board was responsible for part of the program. This difficulty might be eliminated possibly, if the board of education turned over a fixed amount for nursing service to the board of health, leaving the latter as the administrator.

One or two mentioned the need of better qualified public health nurses for the program and of a more thorough and careful introduction to the field and staff education program.

One agency says: "When generalized nursing was first started, the doctors in charge of the various branches of the work were inclined to feel that their particular field was being neglected but that feeling has gradually died down and we have very few complaints. Our annual reports show that the work is evenly distributed and we are able to carry on the work as directed by the various department heads."

While the cities that are carrying on the generalized plan are few in number their reports are impressive enough to bear serious consideration. There are many in the school health as well as in the public health nursing field who feel strongly that the school nursing program by and large throughout the country has been far from satisfactory. At a time when changes and experiments are the order of the day, the generalized plan of school nursing under the direction of a public health nursing agency may point the way to a more satisfactory and sounder service.

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## ARTICLES OF SPECIAL INTEREST IN THE AMERICAN JOURNAL OF NURSING FOR SEPTEMBER

# CONTRIBUTORS PAGE

MRS. ELMIRA BEARS WICKENDEN was born in Boston, Massachusetts, graduated from the Waltham Training School for Nurses, and has had experience in public health nursing in Cambridge with the Visiting Nurse Association and in school work; overseas war work in France; school supervising in Louisville, Kentucky; as director of the Public Health Nursing Association in Louisville; with the American Child Health Association and the National Organization for Public Health Nursing—in 1923-4, 1928 and 1933. Mrs. Wickenden is a board member of the Eastchester (N. Y.) Public Health Nursing Association and the mother of two promising little public health nurses.

MARY ELLA CHAYER is a frequent contributor to PUBLIC HEALTH NURSING and, as our readers know, is Instructor in Nursing Education at Teachers College, Columbia.

H. E. KLEINSCHMIDT, M. D., has practiced medicine, served as a medical officer in the U. S. Navy, and has held positions with the American Social Hygiene Association and the Ohio State Department of Health. His present position is that of Health Director in the National Tuberculosis Association, New York, N. Y.

MARION G. RANDALL contributed an article on "Records and Statistics" in August, 1932, PUBLIC HEALTH NURSING. She is a staff member of the Division of Research, Milbank Memorial Fund, New York.

MRS. HELEN NORTHRUP KNAPP is a graduate of Peter Bent Brigham Hospital School of Nursing, Boston, Mass. She has been teaching supervisor of surgical nursing, Bellevue Hospital, New York City, school nurse in Miss Chapin's School for Girls, New York City, and at the time of writing this article is camp nurse at Broadview Camp for Girls, Sharon, Conn.

DR. HAROLD H. MITCHELL was Director of School Hygiene, Fall River, Mass., from 1924-25. For the last few years he has been a Medical Associate of the American Child Health Association and served as Medical Director of its School Health Study. He is a Fellow of the American Public Health Association, the American Medical Association, and the American Academy of Pediatrics. On September 1st he will assume the position of Director of School Health in Freeport, New York.

RUTH B. FREEMAN, R.N., graduated from Mt. Sinai Hospital Training School, New York City, in 1927. After a few months of private duty, she became staff nurse with the Henry Street Visiting Nurse Service; she is at present supervisor of the 79th Street branch.

HELEN F. MURRAY is a graduate of the Crouse-Irving Hospital, Syracuse, New York, and has taken courses in health education at Oswego Normal School and New York University. She held the position of health teacher in Delaware Academy, Delhi, N. Y., and for the past six years has been school nurse-teacher in the public schools of Baldwin, N. Y.

GENA M. JOHNSON taught school for nine years before training at St. Luke's Hospital in Fargo, N. D. She took post-graduate work in public health nursing at the University of Minnesota and for the last few years has been school nurse for Cass County, N. D. Since presenting this paper she has married and is now Mrs. John B. James.

## JUDGES ANNOUNCED

The judges for the radio sketch contest conducted by this magazine are:

W. W. BAUER, M.D., Director, Bureau of Health and Public Instruction, American Medical Association, Chicago, Illinois.

MRS. GEORGE KUCHLER, La Grangeville, New York.

AGNES G. TALCOTT, R.N., Director of Nurses, Department of Health, Los Angeles, California.

# NOTES *from the* NATIONAL ORGANIZATION FOR PUBLIC HEALTH NURSING, INC.

*Edited by* KATHARINE TUCKER

## PREPARATIONS FOR THE FALL

Preparation for fall meetings throughout the states has kept the N.O.P.H.N. staff on its toes during the summer months. A new booklet entitled "Keeping Ahead of the Tide" is ready for distribution at state meetings. Through its pages flow important bits of information about the N.O.P.H.N.—its aims, its contributions to the field of public health nursing, the services it offers to its members with note of its services to special groups as board members, school and industrial nurses. The booklet concludes with a section on "How to Become a Member." It is hoped that the reading of this booklet will encourage nurses and interested laymen to keep ahead of the tide through membership in the N.O.P.H.N.

A more conspicuous device for state meetings is a new N.O.P.H.N exhibit consisting of a large three panelled cardboard poster which can be placed on a display table. A silhouette of a public health nurse is superimposed on a shadow map of the U.S.A. over which is the caption "N.O.P.H.N.—A Nation-Wide Service."

A new poster is also in preparation and will be ready in the Fall.

We are interested in having as far in advance as possible the dates and places of state and local meetings so that this attractive new material may reach every one. As usual it is available without charge.

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On August 16 and 17, Miss Haupt attended the 26th Annual Convention of the National Association of Colored Graduate Nurses, which was held in Chicago. Two members of this group are on N.O.P.H.N committees to the end that the nursing aspects of Negro public health work may be encouraged.

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## HONOR ROLL

*Agencies reporting 100% nurse membership in the N.O.P.H.N., June-July, 1933*

**CALIFORNIA**
- Needles Welfare Board, Needles
- Yolo County Health Department, Woodland

**CONNECTICUT**
- Visiting Nurse Association, Bridgeport
- Visiting Nurse Association, Waterbury

**ILLINOIS**
- City Department of Health, Evanston

**IOWA**
- Public Health Bureau, Muscatine

**KANSAS**
- Visiting Nurse Association, Kansas City

**KENTUCKY**
- Madison County Health Department, Richmond

**MASSACHUSETTS**
- Canton Hospital and Nursing Association, Canton
- West Springfield Neighborhood House Association, West Springfield, Mass.

**MICHIGAN**
- Visiting Nurse Association, Detroit

**MINNESOTA**
- Visiting Nurse Association, Minneapolis

**NEW JERSEY**
- Camden County Tuberculosis Association, Camden
- Bureau of Public Health Nursing, Montclair
- American Red Cross Public Health Nursing Service, Rahway
- Public Health Nursing Association, Red Bank
- Metropolitan Life Insurance Company, Union City
- District Nursing Association, Westfield

**OHIO**
- Western Reserve University Public Health Nursing District, Cleveland

**OKLAHOMA**
- Oklahoma City Public Health Nursing Bureau, Oklahoma City

**TEXAS**
- Fort Worth-Tarrant County Tuberculosis Society, Fort Worth
- American Red Cross Public Health Nursing Service, Galveston
- Lower Rio Grande Valley Nursing Service, San Benito

# BOARD AND COMMITTEE MEMBERS FORUM

*Edited by* KATHARINE BIGGS MCKINNEY

## MOBILIZING THE PUBLIC FOR 1933-34

One of the unique features of the Cincinnati, Ohio, Community Chest campaign last year was the organization of the Women's Crusade. Women in every walk of life and every district in the community were enlisted as individual publicity agents for the social welfare program of Cincinnati. They were commissioned with the undertaking "of educating the people of the community to what the situation really is." This crusade was a vital factor in the success of the Community Chest drive in Cincinnati, and the story of their achievement has gone far and wide over the country.

Again this Fall every community and every agency is to be faced with the need of raising money to carry on the community welfare program. Although the "New Deal" and the courageous efforts of the N.R.A. program are accomplishing much in putting the nation on the path to recovery, there is every indication that there will still be tremendous need this coming year for constructive social planning and service, for nursing care and health instruction, as well as for relief. As the relief program is more and more swinging under the auspices of the official agencies, a greater challenge is presented to the community to raise by private subscription the funds necessary for constructive welfare work.

As last year, there will be a national committee with Mr. Newton D. Baker as chairman to head the campaign, which this year will be called "Mobilization for Human Needs." There will be a National Women's Committee under the leadership of Mrs. Franklin D. Roosevelt, with state and local chairmen, "to lead women in local communities to strengthen convictions of necessity for human services." The campaign will start October 15, 1933.

Each and every public spirited individual should appoint himself a committee of one to educate those about him in regard to the program of health and welfare in his own community. Facts should be at hand in regard to the need that exists in that community and the program of the agencies that are meeting this need. Case stories illustrating the work of the agencies should be available to strengthen the believer and to disarm the skeptic and the critic.

Here is an opportunity for each board member to take an active part in this nation-wide campaign for "Mobilization for Human Needs." Board members in many communities have done outstanding work these past few years in interpreting the service of their agency to the public, and from every indication they are preparing for this Fall with greater purpose than ever before.

Without question the most effective weapon in the publicity campaign is the case story. Following are several stories, gleaned from various agencies, that speak for themselves.

### FIVE PAIRS OF EYES SALVAGED

"To save one pair of good eyes threatened from the ravages of a most damaging infectious disease means a lot of hard work, but to help save five pairs of good eyes in one family is a real feat of good nursing and coöperation.

"One day the nurse was called to a home in the southwestern part of the city to see the two little boys who had what the mother thought was pink eye. The nurse realized at once that it was a very serious infectious disease. She gave first aid treatment, advised the mother of the probability of the severity of the condition, that they must have a doctor. The mother said she would wait till the father returned at night.

"The nurse was worried lest the father would not consider it as serious as it was, so she made an evening visit to talk with the father. By this time three others, including the mother had indication of the infection.

"The father by this time greatly alarmed called the family physician. He came soon and made a diagnosis which confirmed the nurse's fears. He prescribed treatment at once and to be kept up absolutely without fail. The father stayed all night working alone with his loved ones, and early the next morning the nurse came to treat these painful, swollen eyes.

"One call was not sufficient, four times a day for several days the nurse called on what she termed her 'eye hospital'. Through the long hours of those several weary days and nights, the mother praying for her children's eyesight to be spared, did not realize how nearly she came to losing her own. At last an improvement began to manifest itself, gradually the inflammation subsided, and in a few days the dreadful ordeal was over.

"What if the visiting nurse had waited until the next day to call and warn these people of their danger? There would have been five more sightless persons in Kansas City, Kansas, today. There is rejoicing in this home over the services of the Visiting Nurse."

**"ALL IN THE DAY'S WORK"**

"Here's a miracle of another kind. A Henry Street Visiting Nurse this year went to see a young mother in a kitchen bedroom, where she lived with her two little girls. She was to have a baby soon. Since the death of her husband some months before, she had eked out a wretched existence by doing odd jobs of various kinds; but with the approach of her confinement, she could no longer buy the bare necessities of life A neighbor had suggested that she put the two children in a Home, but she couldn't bear the thought of that. They were such very little girls, only three and four years old—and to put them in some big institution—oh no! She couldn't bring herself to that! So she dragged on in bitter despair, until one day a Visiting Nurse found the two famished small girls on the floor fighting over a crust of bread, and the mother standing by a sink with a bottle of bichloride of mercury gripped in her hand. When the poison was taken away, she broke into shuddering sobs. The nurse put her to bed and talked to her in soothing, quieting, sensible tones, promising to see her through. Relief supplies were provided that same day; and only a few nights after that, with a blanket strung across the room to keep from the children's eyes the wonder and the agony, a little boy came into the world—and so changed the world for his mother that she was ready again to take up the fight. The nurse got a neighbor woman to help and came herself every day until it was safe to leave them. A widow's pension was secured and the nurse gave her assurance of steady friendship and support. So four lives were saved. A miracle! But one that came not through blind chance but through this organization of trained, devoted women who now appeal to you for aid."

**"72 LINDALE STREET"**

"An ordinary house, an ordinary street, but inside this house lies our 'sick-a-bed Mother' and she is to the family as the hub is to the spokes of a wheel, holding them altogether.

"It is now five years since she became our 'sick-a-bed Mother' due to an automobile accident. All this time she has lain motionless, paralyzed completely from her neck to her toes. She is able to move her arms a wee bit, maybe to scratch her nose or rub her chin and can shift her head from side to side. That is all.

"They are plain working people, the family consisting of the father, three children and a niece, Helen, age 16 years, who does the housework and looks after the children. Mitchell, age 13, is the oldest and will enter high school in the fall. Zggy, age 10, and Felice, 8, go to the Polish school.

"The family revolves around the mother, her room is the council chamber, her bed the seat of judgment. All questions that arise are brought before her and should too much noise occur in the kitchen such as loud talking or squabbling, a word from her and it is enough. Zggy is the master of ceremonies. It is he who waters his mother's plants more or less disastrously to the furniture. He brings in flowers, reads to his mother before going to school, sets up her reading table and tries to help her turn her pages with a specially designed contrivance that was planned for her by the Junior League dentist and obtained through the

coöperation of a relief agency. This consists of an aluminum rod attached to a rubber plate which fits over her teeth. In the rod can be placed a pencil and it is hoped that by degrees she may learn to write as well as turn her pages. Felice also would never think of leaving the house or coming in without going at once to her mother's room. Mitchell, the oldest, is the same.

"When the nurse first visited this house the atmosphere was very different, the discouragement great, but little by little cheer has crept in and the mental attitude of the patient and of the family has changed. The daily visit of the nurse soon became an event to which all looked forward. Her eyes were tested and reading was encouraged, her teeth examined and put in good condition.

"A feeling of security was created, a feeling of hope, so that when the family felt the pinch of the depression as many others have done this past year, they could feel they did not stand alone and that aid would be supplied to relieve their worries. Could we not all learn a little from our 'sick-a-bed Mother' who is fighting her brave fight against such fearful odds, and in spite of it all faces her little world with such courage and bravery?"

"Quoting the father of one little girl patient—'Nurse, I wish the Community Chest people could see the improvement in my little girl, if they knew what has been done for her by the District Nurse Association, they wouldn't mind filling the Chest.'

"This little girl, now 4 years old, was paralyzed, unable to move, all muscles affected. She is now running out of doors alone with slight limitation and no deformity."

These are just samples; every agency in the country can produce stories as moving as these. And the board member who can tell his neighbor in a simple but convincing way the facts about the work of the public health nurse in his community and can illustrate it with one or two stories such as these, is doing his share in the mobilization program.

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## STUDY COURSE FOR BOARD MEMBERS 1933-34

We are taking it for granted that by this time our board members are so intrigued with study courses that they are looking forward eagerly to one this coming year. This year the course will be organized a little differently from those of the two previous years. The first course was sent out month by month to the organizations which requested the material, and consisted of questions and reference readings on such subjects as: The Community Health Program; Public Health Nursing Program for a Community; Standards, Qualifications, and Salaries for Public Health Nursing Positions; Relationship to Medical Profession; Maternity, Infancy, and Preschool Program; Acute Communicable Disease Control—Tuberculosis, Syphilis and Gonorrhea; Statistical Data and Costs; The National Organization for Public Health Nursing. Free copies of this course are still available for any organization which has not made use of the material and would like to do so.

Last year's course on Publicity was published each month in the Board Members' Forum of the magazine, PUBLIC HEALTH NURSING, starting with the September number and continuing through May. The topics included such subjects as Printed Matter, Use of Radio, Exhibits, Annual Meetings, etc. Reprints of this course are available free to members of the N.O.P.H.N. or 75 cents for the set. This is an excellent series for your publicity committee to have.

This year on October 1st we shall send out an outline—in topic form—of the entire year's course to all our corporate members, and an announcement will go also to others who have taken the previous courses. This will give the opportunity to plan and assign the winter's work in advance. There will be no charge for the series. Any who do not receive an announcement and who would like to have the outline, please notify the secretary of the Board and Committee Members Section, Evelyn K. Davis, N.O.P.H.N., 450 Seventh Ave., New York.

# REVIEWS AND BOOK NOTES

*Edited by* DOROTHY J. CARTER

## THE ADOLESCENT BOY

By Winifred V. Richmond, Ph.D. Farrar and Rinehart, Inc., New York. Price $2.50.

The subtitle of this work is "A book for parents and teachers." Unless under the term "teachers" are included many whose vocation is not strictly listed as that of teachers, I believe that this subtitle should be extended to include doctors, nurses and social workers; in fact, this valuable volume on the problem of the adolescent boy should be in the hands of all those whose work at any point touches that of young manhood. Still dealing with the subtitle, I feel it is barely possible that there may be some unstable parents who should not have the book placed in their hands unless a wise physician or teacher could interpret some of its meaning for them. I could think of many over-suggestible parents who might be somewhat upset over the chapters on "Deficiencies and Abnormalities" and "The Delinquent Boy," unless their path through these chapters is clearly charted for them by an understanding guide. With this one mild suggestion, the remainder of this review must be entirely laudatory. I have looked through the various chapters endeavoring earnestly to find overstatement, mis-statement or understatement but, frankly, have failed to do so.

Doctor Richmond's book is written from a background of tremendous experience with youth and, best of all, with a foundation of unusual understanding. The whole boy during his entire adolescent period is dealt with most frankly, clearly and constructively. In the eight chapters we gain an accurate understanding of the historical approach to the adolescent boy; we learn of the modern conception of puberty and its problems; we are told of the deficiencies and abnormalities of the period; we gain a clear understanding of the delinquent boy, and then we come to a careful exposition of the normal youth and his problems, the boy at college and the young man in a changing world. The reward for those who read this book is very great for they will gain a complete, up-to-date and challenging understanding of the boy of today, his weaknesses, his strength and his opportunity; and in a time when the world must lean heavily upon the younger generation to lead it out of its complexes and conflicts, this is, indeed, a rich reward.

For a long time it has been said that if we are to understand human problems we must learn them at the earlier age levels. Here is an opportunity to learn about boys from an expert who writes clearly, is not afraid to face facts and yet remains an optimist. All too frequently we must wade through books in which we must separate the wheat from the chaff. Here is one that from beginning to end is filled with facts, and the application of these facts to our dealings with human beings is made clear. In addition to all of the valuable material contained in the text of this book, there is also at the end of each chapter an excellent authoritative and up-to-date bibliography.

The viewpoint represented in the book is in no way theoretical, does not favor any special school of thought but, rather, takes the best from all schools and applies the author's own wisdom and clarity in their interpretation and exposition. "The Adolescent Boy" is a real contribution to our vast amount of psychiatric and psychologic material concerning the childhood problem. It stands out as one of the most valuable contributions to this age period and the reviewer predicts it will for a long time prove a standard work concerning the mental and social development of boys. For many years those

dealing with intangibles concerning human beings have been asking for more accurate yardsticks; here is one of the best which combines with its accuracy a quality often conspicuous by its absence in similar works—namely, good common sense.

ARTHUR H. RUGGLES, M.D.

**PUBLIC HEALTH NURSING IN INDUSTRY**

Prepared for the National Organization for Public Health Nursing. By Violet H. Hodgson. The Macmillan Company, New York. 1933. Price $1.75.

For many years industrial nurses have needed a manual to guide them in their work. This volume appears at a most propitious time, the inception of industrial recovery.

The purpose of the book according to the author is to indicate the potential field of public health nursing in commerce, trade, and industry. It is believed that the material will (1) indicate to management the potential field of activity of the public health nurse; (2) assist the new nurse entering the industrial health field in planning the most effective program possible; (3) suggest to the nurse in industry new lines of activity; (4) suggest the functions of the nurse and her administrative relationships to the medical, industrial relations, and production departments; (5) assist the nurse in making her service an integral part of the community health program; and (6) stimulate community public health nursing agencies to extend their programs into commercial and industrial establishments.

In the introduction are given a brief history of nursing, the distribution of industrial nurses in the United States, and a discussion of the potential field to be covered.

The book is divided into two parts, Part I embracing company organization and administration, with especial relationship to nursing service. This part contains chapters on company organization, industrial relations activities, health service, and interrelationships. Well selected graphs help to make the text of this part easily understandable.

Part II deals with the nursing service and considers the principles, practices and procedures to be followed in a sound industrial nursing program. The fundamental principles are those pertaining to the general field of public health nursing, and Mrs. Hodgson has been particularly successful in demonstrating how these apply to nursing in industry.

Other chapters in Part II pertain to human relations within the plant; scope of the work within and without the plant; administration of nursing service by various agencies; physical equipment of health departments; care and prevention of accidents and illness; industrial poisons; diseases related to industry; supervision; community relationships; the work environment; records and statistics; costs; and future trends.

Two appendices give an outline of objectives and principles, and a suggested course of study on industrial nursing. In addition to copious references used as footnotes throughout the book, a third appendix contains a well selected general bibliography.

Of especial interest to the modern public health nurse in industry should be the material discussed in Chapter 11 on work environment and in Chapter 12 on records and statistics. From a practical point of view, the information contained in these chapters, if properly applied, should pay big dividends for the efforts expended. The material in Chapter 13 on costs is of equal value.

Occasionally a book appears reflecting an adequate treatment of the subject, a discriminating selection of material, and excellent literary taste—this volume fulfills all these criteria. It is stating the obvious to say that it should be a part of the personal library of every industrial nurse; it might properly be used as a reference book or a textbook in nurses' training schools; and finally, it should be welcomed in all medical libraries.

C. O. SAPPINGTON, M.D.

**TEACHING NUTRITION TO BOYS AND GIRLS**

By Mary Swartz Rose. The Macmillan Company, New York. Price $2.00.

"Teaching Nutrition to Boys and Girls" by Mary S. Rose is one of the most practical books that has been writ-

ten on the subject. It is really "useable" from the first line of the first page to the end.

The methods of teaching suggested have been proven to be effective by actual experiment in the classroom over a period of years. The subject matter taught is accurate in every detail, the source of each statement of fact being given. An attempt is made to appeal to the desires of children of various ages so that information will not be just "plastered on", but a motive for, and a desire to adopt health habits of eating will be created. While the book deals strictly with the subject of food, the author emphasizes the fact that other phases of health education must be taught as they are all essential to good nutrition.

The subject matter of the book is divided into four units of lessons; each unit being subdivided into ten lessons. A preliminary summary at the beginning of each unit outlines the points to be taught, giving the reasons for teaching and the method best adapted to the purpose. Following this introductory synopsis is a complete outline or lesson plan for each of the ten lessons in the unit. The illustrative material to demonstrate each point is definitely designated. Each lesson plan ends with an assignment to be prepared outside of the classroom before the next lesson.

Any classroom teacher even though unfamiliar with the nutrition field can take this book and learn along with her pupils, without additional work on her own part. Sources for illustrative material are given in the Appendix. Exact instructions as to the care of animals used to illustrate the effect of food on growth and development are also included. A child who completes all four units of lessons should have not only a knowledge of what constitutes good food habits, but also a desire to follow such practices himself. In addition, he will have an intelligent idea of food elements and their effect on the body.

This book is of value to the health education director, to the classroom teacher, and to the nutritionist in planning their teaching program.

EMILY L. KETCHAM

**MOTHERCRAFT FOR OLDER GIRLS.**
By Hester Viney. Faber & Faber, London. Price 3/6.

The author, through her work with young women and girls in England, and with mothers and children in all classes of society, appreciates the need for educated motherhood; and so this book is the outcome of years of experience.

A handbook implies brevity, yet pertinent scientific facts have not been sacrificed. In a simple, direct manner, with understanding, Miss Viney has given salient information for older girls concerning the growth, development and care of the young infant from the prenatal period until two years of age. This includes the care of the mother, the feeding of the baby, the importance of clothing, and one part is devoted to character training and the influence of the home.

The book is well organized, clear and to the point. The illustrations are full of human interest, and her clever, intelligent use of diagrams makes a very meaningful and graphic presentation of ideas.

"Mothercraft" is particularly valuable to public health nurses, especially school nurses, who are teaching courses in child care and development, as it is comprehensive in scope and contains a selective bibliography.

JESSIE T. PRISCH

**USEFUL BOOKS AND BOOKLETS**

SCHOOL NURSING—A CONTRIBUTION TO HEALTH EDUCATION. Mary Ella Chayer. Putnam. $2.50.

HEALTH AND HOME NURSING. George Margaretta Douglas. Putnam, $2.50.

FIRST AID TEXTBOOK. American Red Cross. Revised 1933. 60c.

PRINCIPLES OF HEALTH EDUCATION. Clair E. Turner. D. C. Heath and Company, $2.00.

BROADCASTING HEALTH. Andress and Goldberger. Ginn and Company. 80c.

WHITE HOUSE CONFERENCE REPORTS. Century Company.

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Although the "Foreword" of *An Evaluation of School Health Procedures* states that it "is written more particularly for the non-statistical reader", many parts of it seem pretty technical to the uninitiated. This does not invali-

date, however, the extremely important findings reported in this fifth monograph of the American Child Health Association's School Health Study. Some of the significant results of this detailed and carefully checked evaluation of procedures are as follows:

The teacher has an important function in selecting and referring the child for examination and follow-up.

Nurse-teacher rapport is one of the most vital factors in producing results in a health program.

Teacher and nurse knowledge most valuable to school health is knowledge of the child and method rather than professional information.

The school health world will look forward with interest to the summary volume of this significant study to be published shortly. School Health Research Monographs, Number V, American Child Health Association, 450 Seventh Avenue, New York, N. Y.

### NUTRITION

Nutrition is one of the most important phases of the school nurse's program at the present time. An up-to-date list of publications on low cost diet can be procured for 6 cents from the Social Work Publicity Council, 130 East 22nd Street, New York.

Two bulletins on *School Lunches* and *Food for the Child* have been prepared from authoritative sources by the New York *World-Telegram* and may be procured at 5 cents each from that newspaper at its Washington Information Bureau, 1322 New York Avenue, N. W., Washington, D. C.

"The Relation of Nutrition to Dental Health" is the name of a three-reel film for educational purposes prepared by Castle Films, Film Center Building, 630 Ninth Avenue, New York. Available without cost.

### FOR STUDY GROUPS AND PTA'S

YOUR CHILD AND HIS PARENTS. A textbook for Child Study Groups. Alice C. Brill. Iowa Child Welfare Research Station, State University of Iowa, Iowa City.

PROGRAM ON CHILD TRAINING, 1933-34. Also study course on the Preschool Child, 1933-34. Parent's Magazine, 114 East 32nd Street, New York, N. Y.

ALL-ROUND HEALTH. A study course for PTA's and other parent groups. Child Welfare, The National Parent-Teacher Magazine. September, 1932—May, 1933.

DEVELOPING CHARACTER IN YOUR CHILD. Study course for 1933-34 commencing September. Child Welfare.

Also in Child Welfare suggested topics for Parent-Teacher programs commencing September, 1933.

A mimeographed outline of *Suggestions for a Program of Eye Health in a School System* has been prepared by the National Society for the Prevention of Blindness and can be procured from that organization at 450 Seventh Ave., New York.

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## NOTEWORTHY ARTICLES OF THE CURRENT YEAR

*(For articles appearing previous to September, 1932, see Book Notes department of past September issues)*

**Adjustments in the school nursing program.** PUBLIC HEALTH NURSING, March, 1933.

**Adolescence.** Several articles by authorities. Understanding the Child, Masschusetts Society for Mental Hygiene, January, 1933.

**Are the "nerves" and badness of childhood of any importance to the field of public health?** Esther L. Richards, M.D. American Journal of Public Health, March, 1933.

**Curriculum problems in sight-saving classes.** Winifred Hathaway. Sight-saving Review, September, 1932.

**Don't worry about sleep.** Gertrude Porter Driscoll and Martha May Reynolds. Parents Magazine, May, 1933.

**Factors in the etiology and arrest of dental caries.** Ralph Howard Brodsky. Journal of the American Dental Association, August, 1933.

**Foods all families need.** Lillian Anderson. PUBLIC HEALTH NURSING, April, 1933.

**Health education demonstrations in Massachusetts high schools.** Frank Kiernan. Hospital Social Service, May, 1933.

**Health examinations of college students.** F. G. Norbury, M.D. Illinois Medical Journal, April, 1933.

**Health examinations in schools.** H. E. Kleinschmidt, M.D. School Physicians' Bulletin, April, 1933.

**Heart disease in children.** Lucy Porter Sutton, M.D. Hospital Social Service, Supplement No. 2, July, 1933.

**Is school nursing a fad and frill?** George D. Strayer and Mary Ella Chayer. PUBLIC HEALTH NURSING, July, 1933.

**Juvenile delinquency and education.** Journal of Educational Sociology. April, 1933.

**Mental hygiene—its future in public education.** Caroline B. Zachry. Journal of the National Education Association, May, 1933.

**Preventing school bus crashes.** Curtis Billings. Public Safety, August, 1933.

**Prevention and treatment of ringworm of the feet.** C. C. Wilson, M.D. School Physicians' Bulletin, April, 1933.

**Problems rural school teachers are facing.** George C. Kyte. Nation's Schools, April, 1933.

**Recognition and control of tuberculosis of childhood.** E. L. Opie, M.D. American Journal of Public Health, April, 1933.

**The Retarded Child in the Rural School.** Annette Bennett. Mental Hygiene, July, 1933.

**School children's nutrition clinic.** Anna E. Boller. Child Health Bulletin, September, 1932.

**Sex education and mental hygiene.** Two articles by Ira S. Wile, M.D., and William A. White, M.D. Journal of Social Hygiene, May, 1933.

**Sex education for adolescents from the viewpoint of the teacher.** F. H. Richards, M.D. Hospital Social Service, January, 1933.

**Shall school nurses give relief?** PUBLIC HEALTH NURSING, December, 1932; January, March, 1933.

**Some dietary studies of Poles, Mexicans, Italians and Negroes.** Alberta B. Childs. Child Health Bulletin, May, 1933.

**Special education number.** Articles dealing with the deaf, crippled, mentally retarded, etc. Journal of Educational Sociology, February, 1933.

**Teaching family relations.** Newell W. Edson. Journal of Home Economics, March, 1933.

**Teaching health.** Series of articles in the School and Health Section of Hygeia, January-March, 1933.

**The development of a health program in a rural consolidated school.** Alfred Campbell. Hoosier Health Herald, June, 1933.

**The nurse's opportunity in hookworm disease.** Ch. Wardell Stiles. PUBLIC HEALTH NURSING, August, 1933.

**The school lunchroom—an important cog in the teaching machine.** Flavilla Normington. Nation's Schools, April, 1933.

**Toward better school health programs.** George I. Palmer. Child Health Bulletin, March, 1933.

**Training and growth in the development of children.** Arthur T. Jersild and Associates. Teachers College Record, April, 1933.

**What contribution may the local health organization render a junior high school in developing a health education program?** I. G. Smith. New England Journal of Medicine, August, 1932.

### PAMPHLETS AND SOURCE MATERIAL

Facts About Juvenile Delinquency: its prevention and treatment. Publication No. 215, Children's Bureau, United States Department of Labor, Washington, D. C.

Health Through the Ages. C-E. A. Winslow and Grace T. Hallock. Metropolitan Life Insurance Company. A brief but comprehensive summary in simple terms.

Outline for the Psychiatric Classification of Problem Children. Sanger Brown, Horatio M. Pollock and Howard W. Potter. State Hospitals Press, Utica, N. Y.

Schools and Classes for Delicate Children. James Frederick Rogers. Including open-air classes and schools, nutrition classes, preventoria and health camps. 20 cents from the Superintendent of Documents, Washington, D. C.

School Ventilation—Principles and Practices. The report of the New York Commission on Ventilation. Bureau of Publications, Teachers College, Columbia, New York. $1.00.

Spyglass. A quarterly publication of source material for teachers. American Child Health Association, 450 Seventh Ave., N. Y.

Study of Rural School Ventilation. Publication No. 1320, United States Public Health Service, Washington, D. C. 10 cents.

The Social Work Publicity Council, 130 East 22nd St., N. Y., has the following leaflets available at 3 cents each:

Home-Made or School-Made Posters

Posters in School Health Education

Plays—Health. Sources for securing plays and information about play production.

Work of the School Nurse-Teacher. Marie E. Swanson. Health Bulletin No. 4, University of the State of New York Press, Albany, N. Y.

# NEWS NOTES

*Industrial Nurses!* The twenty-second Annual Safety Congress of the National Safety Council is to be held in Chicago, October 2-6. There will be a special session of the Industrial Nursing Section on October 3rd, at which Dr. W. S. Ash, Director of Medical Service, U. S. Tire Company, Detroit, will present a paper on "Safety in Nursing," and Miss Evaline F. Logan, industrial nurse at the Wisconsin Steel Company, Chicago, will discuss "Tying Up the Nursing Program to Personnel Relations."

✠

Twenty-three public health nurses, including one man, graduated this last Spring from the School of Public Health Nursing of the University of the Philippines. The gentleman, Mr. Eugenio Lucero, will work with the Philippine Bureau of Health. (Query—Why not more gentlemen public health nurses?)

✠

A program for mobilizing the youth of the country to assist in the problem of unemployment and leisure time is under way under the auspices of the Committee on Unemployed Youth, with headquarters at 450 Seventh Avenue, New York. With Courtenay Dinwiddie as Chairman and made up of representatives of national agencies interested in welfare and recreation, this Committee has commenced its work by distributing folders to those about to graduate from college and university, urging them to take an active part in a constructive recreational program in their own communities. Local leaders are being selected to whom the graduate may go for information and assistance. A manual of community projects and programs is in preparation and will be ready in the Fall.

✠

Again it has come time to note the graduation of another group of "Internationals" from the courses offered by Bedford College and the College of Nursing in London. This is the thirteenth year of this postgraduate course for nurses which has received worldwide recognition and has sent out in all 221 nurses well prepared for every field of nursing, most of whom have returned to their own countries to promote and develop nursing interests there. Thirteen students graduated this year receiving their certificates from Dr. Alice Masarykova, president of the Czechoslovak Red Cross Society. The names of students who have completed the public health course are as follows: Marie Bettendorff, distinction in all subjects, Luxembourg; Swatt Dharmasaroja, Siam; Veronika Monkuté-Monkeviciute, Lithuania; Sarah Isabella Johanna Nel, South Africa; Vinka Sôljan, Yugoslavia; Cécile Theys, distinction in public health nursing, Belgium; Marie Sylvie Agnes Weiss, Queen's Nurse, distinction in psychology, Great Britain; V. Caroline Wickham, Queen's Nurse, distinction in hygiene and public health nursing, Great Britain; Frantiska Zidová, Czechoslovakia.

✠

On August 1, four nursing services in St. Joseph, Missouri, merged into one organization to be called the St. Joseph Organization for Public Health Nursing. The agencies involved were the Visiting Nurse Association, the Baby Welfare Association, and the nursing services of the Buchanan County Chapter of the American Red Cross and of the Buchanan County Society for Relief and Prevention of Tuberculosis.

✠

A course in "School Hygiene as Related to Community Health" is being offered this Fall by the Institute of Education at New York University to be given to groups of teachers in their own communities. Ethel A. Grosscup, Field Adviser in the Child Health Education Service of the National Tuberculosis Association will be in charge of the course.

Further information may be secured from Prof. Ned H. Dearborn, Director, Institute of Education, New York University, Washington Square, New York.

✣

The Michigan Board of Registration of Nurses will hold an examination September 28-29 for graduate nurses, September 28 for trained attendants, at the Book-Cadillac Hotel, Detroit. All applications with fees must be on file in the office of the Board of Registration of Nurses, 200 Hollister Building, Lansing, not later than September 13. Mrs. Ellen L. Stahlnecker, R.N., Secretary.

The Michigan Board of Registration of Nurses will also hold an examination October 12-13 for graduate nurses, October 12 for trained attendants, at the Olds Hotel, Lansing. All applications with fees must be on file in the office of the Board of Registration of Nurses, (address as above), not later than September 27.

✣

Eleanor K. Harper of Cincinnati, Ohio, has been awarded the Health Education Scholarship for 1933-34 offered to a public health nurse by the Massachusetts Institute of Technology. Miss Harper is a graduate of Ohio State University and of the Battle Creek School of Nursing and has had several years' experience in school nursing, her last position being with the Kellogg Foundation, Battle Creek, Michigan.

✣

An International Congress on the scientific and social aspects of the campaign against cancer will meet in Madrid, October 25-30.

✣

### RECENT APPOINTMENTS

A. Fiddis Clark, R.N., has accepted a position with the Peter Carter Kohler Swiss Chocolates Company as industrial nurse.

Nellie Nash has been appointed nurse in charge in the newly organized full-time nursing service in Lincoln County, West Virginia.

✣

Aroused by the prospect that thousands of children may be deprived of school privileges this fall, leaders of the National Congress of Parents and Teachers at the semiannual meeting of the National Board of Managers in Washington, D. C., September 18 to 21, will consider definite plans for mobilizing public support for stricken schools during the coming year.

Parent-teacher associations have been instrumental in keeping large numbers of children in school throughout the educational crisis. According to present plans, they will make an effort this year to arouse all citizens to the need of maintaining educational standards.

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Our readers will be glad to know that both the printer of our magazine and our engraver have signed the N R A code. They are:

Thomas J. Griffiths Sons, Inc., Utica, N. Y.
Horan Engraving Company, Inc., New York, N. Y.

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